Medical

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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Christophe

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		1- For State Registrar		are or maryic	•	tificate o		unu mo		_	Reg. No	2006	3600	
nysicia Exami	an/	1. Decedent's Nam	stophe	r Michael on, give street and no		s	4b. City, Tow	n, or Location		2. Date of De Month Novemb e	Day er 9, 2	Year	3. Time of Death 1300 hrs	
		Saint Agnes				yrs, last birthday) If Under 1 Year If Under 24Hrs, 8.1					N/A te of Birth(MM/DD/YYYY) 9. Birthplace (State or			
neral ector		5. Social Security N		6 Sex	7. Age (In yrs. Ia	ist birthday) Yr		Days Hou		1	•	Foreig		
show any ICE.	ı	Usual Residence of 10a. State	10b. County			Town or Loca	tion						10d. Inside City Limits 1 Yes 2 No	
3a or 28a-f	Director	10e. Street and Nu 1033		ey Ave.		10f. Zip Code 21223					itizen of What Cour	ntry?		
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Marri 3 Widowed	ied 2 X M		2 X No		as Decedent of Yes, specify C		n, Puerto F		0-	14 Race - Americ White, etc.		
ihan "natur dical Exami	Completed t	15. Decedent's Elementary/Second 12		confy only highest gra	de completed) 1-4 or 5+)	during r	nt's Usual Oct nost of working erviso1	g life. DO NO			16b.	. Kind of Business/li	ndustry	
ntal Hygien rked other ent, the Mo	Be Corr	17. Father's Name unknowi		, Last)				18.Moth		First, Middle,		n Surname)		
Ith and Me n 27 is ma numatic ev	ပ		Willia	ship(Type,Print) NS, wife		103	3 Parks	sley A		Baltim	ore	<u>*</u>	223	
nent of Hea ant: If iten or other tra				n 3 Removal f			sition (Name of ther place) dge Mer		Park	11 - 14		Elkridg		
	1	21. Signature of Fu	uneral Service	ougher	9	Ai 1	Name and Administration Name and Administration Adm	Funer	al Ho	me, In	c År	butus. MI		
ician				r complications that o	caused the death.	Do not enter	the mode of d	ying, such as	cardiac or	respiratory a	rrest, s	hock, or heart	Approximate Interval	

Phy: /Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in 99 the funeral director, page 2 should be detached for use as the burial - transit

Be

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Medical Certification:

Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final disease

or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical X UNPENDED AMENDED perME, g862, 12/21/06 TT 27,28a-f IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24 able of

Narcotic intocxication

la. Was an	24b. Were autopsy	findings avail
autopsy	prior to comple	etion of cause
performed?	death?	
✓ Yes 2 No	1 🗸 Yes	2 No

November 10, 2006

Death

25 Was case referred to medical 26 Place of Death (Check only one) examiner? Other₄ DOA Nursing Home 5 Residence 6 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Naturai 5 Pending 1 Yes 2 X No Fnd 11/9/2006 Fnd 12:30 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1052 Parksley Avenue 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide (Specify) residence Baltimore, MD Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

O.C.M.E.

(Check only 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated 29b Signature and 29c. License number 29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State NOV Registrar

Theodore M. King, Jr., MD.

strar's Signature ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0 0 6 36002 1 - Stata Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October **Physician** 19,2006 0045 Mark Addison /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Randallstown Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) June 18, 1964 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Washington DC Director <u>578-90-6282</u> Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Iteme 23a or 28a-f show the Medical Examiner must be notified a ty⊟Yes 2 □ No Director Washington District of Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ¥. United States 20020 #102 2404 Pomeroy Road SE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: Black þ 3 Widowed 4 Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hyglene. Importent: if Item 27 is marked other than "ne ery injury or other treumatic event, the Mudic once. Elementary/Secondary (0-12) College (1-4or 5+) Caterer Private Tenth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Esther Marshall David Stanley Addison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 69th Place Seat Pleasant, MD 20743 Valerie Phillips-Addison/Wife 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) Nov.8,06 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Riverdale Park Crematory Riverdale, Maryland 21. Signature of Juneral Service Ligensee 22. Name and Address of Facility Robert G. M ason Funeral Home Inc,1661 Good Hope Rd SE, Wash DC 20020 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cay lat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dumy MP DEFICIENCY SYNDROWS Physician rg wred /Medical Du to (or as a consequence of) Examiner Vivus Whom Dumunodoticionry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2000 1 Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ Impatient 2 ER/Outpatient 3 DOA this s efter death. If Director: After this od in by the funeral d 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending Natural investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours of To the Funerel I Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature 29d. Date signed Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) \$2. Registrar's Signature Day, Year) State 1 4 2006 NOV Registrar

State of Maryland / Department of Health and Mental Hygiene, 36003 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Lest) Month 24, 2006 Physician 2:00pm October D. Emma Barnett /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Prince Georges Future Care Nursing Home Clinton If Under 24 Hrs. 8. Date of Birth (Month, Day, May 29, 9. Birthplece (State or Foreign Country) North Keys, Md. If Under 1 Year 6. Sex 7. Age (In vrs. lest birthday) 5. Sociel Security Number **Funeral** Deys Hours 1□ M 2□F Months 86 212-20-1983 Director Usuel Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylend 10c. City, Town or Location 10a State 10b. County th end Mentel Hygiana. 7 Is marked other than "natural", or thams 23a or 28e-f show traumatic event, the Medical Examinar must be notified at 1 No 2 □ No Directo Maryland Prince Georges Upper Marlboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 20772 United States 5305 Spring Dr. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ②No If Yes, Give Year or Detes: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: ۾ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Nurse Medical 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Edis Robinson Mary Ward 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health end Important: if Item 27 Is m any injury or other traum pnce. 5305 Spring Dr. Upper Marlboro, Md. 20772 Edmond Harrod / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 10/28/06 Clinton, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lightsee Name and Address of Facility one Runeral Homes, P.A. 20747 7 0/055 Approximate Interval Between Onset and Death 23a. Pen 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Physician/Medical Due to (or as e consequence of) attanding for use es 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Ś 24b. Were autopsy findings available prior to completion of cause of death? certificete has been si irector, paga 2 should 24a. Was an autopsy performed? Completed 2 XN6 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No this 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No eftar death. 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours e To the Funeral C completaly filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only To the P 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of certifier person who completed cause of death (Item 23e) (Type, Print) LINE CENTER 12070 OLD M.D. 31. Dete filed (Month, Day, Year) OCT 3 0 2006 State Registrar

		1 - For State Registrar	State of M	•	partment of He ertificate of D		Mental Hy	rgiene Reg. No.20	06 36004
Physic	an	1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	eath Day	3. Time of Death
/Medi		Benjamin		ede11				er 20, 2	
Examir	ner	4a. Facility Name (If not institution, giv			4b. City, Town, or I		th	4c. County	
		Prince Georges I 5. Social Security Number 6. S		ge (In yrs. last birthda	Cheve	If Under 24 Hrs	8. Date of Bi	rth	e Georges 9. Birthplace (State or Foreign
Funeral Director		486-24-0599	M 2□ F	82 Yrs.	Months Days	Hours Min	April April	28, 1924	Missouri
and land		Usuat Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
Many f sh	ξ	District of Colu	ımbia	Was	shington				1 X Yes 2 □ No
r 28.	<u>rec</u>	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Country?
th wit	a D	5013 Jay Street	N. E.;	Apt. 13	20019			United	States
d within 72 hours after death with the Maryland jene. I then "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	If Voc Give		3. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 X No	panic Origin? (, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	Blac	e - American Indian, ck, White, etc. :: Black
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Hygi Hygi ther ont,		17. Father's Name (First, Middle, Last,		Dul				, Maiden Suman	
0 2 0	To Be	Albert Bedell	L		ļ	Virgi	inia S	lack	
and Me	-	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street ar			er, City or Town,	State, Zip Code)
27 E		Shirley A. Smothe	ers (Niece	2) 8580	West Farm	Road 8	84; Willa	ard, Mis	souri 65781
of Head	10.3	20a. Method of Disposition 1	Damenton Con	anmotani a	position (Name of rematory or other place	Oct.	27,2006	20c. Location -	City or Town, State
Page nent ant: if ury o		4 □Donation 5 □Other (Specif			i Veterans			Springf	ield,Missouri
permit. Pages to Depertment of H Important: if its eny injury or ot once.		21. Signature of Funeral Service Licer	Chm	*	R. N. Hort 600 Kenned	of Facility on Comp	any Mor	ticians, Washingt	Inc. on,D.C. 20011
Physician		23a. Part I. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cause one cause on each FATAL	line.		such as cardia			Approximate Interval Between Onset and Death
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icien: Th certificete rector, pag	0	25. Was case referred to medical			_	26. Place of De	ath (Check only		<u> </u>
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ii or Atte efter dea i Directo d in by th	Certification;	3 Suicide 6 Could not be determined	286. Place of I	njury - At home, farm, tc. (Specify)	28f. Location (City or To		er or Rural Route Number,		
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J		30. Name and address of person who DR GARY/ ITLE	3001	death (Item 23a) (Typ Hospita	L DR	CHE	VERLY,	MD 20	185
Sta		31. Date filed (Month, Day, Year)	32. Regis	rar's Signature			/		
Registi		OCT 2 7 2006	heren s	1. Sperk					

DHMH 17 Rev 1/2001

			1 - For State amend	State of Ma #1 per Phy	aryland / I G879 5	Department	of H	ealth a	and Me		iene () (06	36005
40	ی Physici	an	1. Decedent's Name (First, Middle,	Last)						2. Date of Dea Month	Dav	Year	3. Time of Death
	/Medic		Annie Lou	Bethea						Octobe	r 14 2	2006	05:30A M
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	ryland how		10a. State 10b. County		10c. City, Tow	vn or Location						1	0d. Inside City Limits
	Ba-1 s	cto	D.C.		Wash	ington							1 X Yes 2 No
	with th	Dire	10e. Street and Number			10f. Zip				1	0g. Citizen of V	Nhat Cour	ntry?
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show dical Examiner must be notified at	Funeral Director	4368 F Street,	S.E.	Ever in U.S.		0019	snanic Oric	nin? (Spec	rify Yes or No-	USA 14 Bac	e - Americ	can Indian
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Maryland	d a b	To Be	John W. McRae							terson		-,	
ary.	should ind Men inarke	1	19a. Informant's Name/Relationshi	p (Type, Print)	198	b. Mailing Address	(Street a	nd Numbe	r or Rural	Route Number	City or Town,	State, Zip	Code)
	1 and 2 Health a sem 27 is		Dorothy R. Savag	e – Daughte	er 9	118 Lough	nran	Road	; Ft.	. Washi	ngton,	MD 2	20744
J. C.			20a. Method of Disposition 1 □ Burial 2 □ Cremation	2 Domaval from State	20b. Place o	of Disposition (Namery, crematory or of	e of her place	9)	Da	ite	20c. Location -	City or To	own, State
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			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caused	the death. Do	not enter the mode	of dying	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence		T o						
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9		Physician/Medical											
Вох	eath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Fetal death	n 3⊡Ectopic pre	onancy					te of delive	,
	ne dea the att	sicia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at 9□Unknown		5 Other (spe					Mo	nth	Day Year
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Records,	The law requires that the site has been signed by the bage 2 should be detache	ted by	Fatti. Other significant condition	s contributing to death b	at not resulting i	in the underlying ca	iusa giva	erini Fatici.			_	3 Prob	1
ecc	e lawr has be ge 2 sh	Completed								24a. Was a autops	y l r	prior to cor	psy findings available mpletion of cause of
= H		Con								perform	No 1	death? 1 🗌 Yes	2 🗆 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Otho			(Check only on			
of	Phys this ral dii	70	1 Yes 2 No 27. Manner of Death	28a. ate of Inju				4 🔲 NUI		e 5 Reside			y)
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Division	or Attending after death. Director: After in by the funer	Certification;	3 Suicide 6 Could no	ot be 28e. Place of Inju	ury - At home, fa	arm, street, factory,						er or Aura	Il Route Number,
Ď	2 분 분 근	Serti	4 Homicide	building, etc	c. (Specify)					City or Towr	, State)		
	To the Hospital of within 24 hours at To the Funerel Completely filled in	edical (Physician: To the best of xaminer: On the basis of and manner sta	f examination ar								
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	100		29c.	. License			1	9d. Date signed	d (Month,	Day, Year)
			1 Denne L	Klein	on F	1 /	200	520	-26	2	10/1	4/6	06
e	(10)		30. Name and address of person w										
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	1	207	44					
	Registr		OCT 27 200	6 General	B. 19	well							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#10cperFH10/31/06. HW MCC. State AMEND#25,280,C,281perME10/30/00HW, Mccertificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day
Octos(n 25 2158 **Physician** BUTCHER 2006 Deborah /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMONE BARTININ 57 R Conless If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days 1 □ M 2√□ F 47 Yrs Maryland 218-76-4177 11-18-1958 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2 No Maryland Montgomery Gaithersburg Gaithersburg ar than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13400 Walnutwood Lane 20874 United States Funeral 14. Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes ŽXNo If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No imore, Maryland 21215-0036 Specify Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) marked other than Head Teller Banking 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Virginia Jean Brown John Howard Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 13400 Walnutwood Lane, Gaithersburg, Md 20874 of Health Gary M. Butcher-Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: If its any Injury or o to 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 10-30-2006 Brentwood, MD 21. Signature of Fune a Service Licensee 22. Name and Address of Facility ville Pike, Rockville, MD 20852 pilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. 23a. Part1 Enter the disease, or conshock, of heart failure. Let only Immediate Cause (Final disease or condition resulting in death) CANDIOPULNONANY **Physician** /Medical Due to (or as a consequence of): Examiner INTERCRANIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): EJECHON Division or Vital Records, P.O. Box 68760, death certificate be IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9⊠Unknown 5 Other (specify) signed by the a 9X Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 **2** No 1 ☐ Yes 🗶 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1X Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Mate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred uneral 27. Manner of Death 10 12 AM After CR ASHI 1 Natural 5 Pending investigation MOTOR VEHICLE 1 ☐ Yes 2 No after death. 2 Accident 20 2006 filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) Observation Dr. & Shakespeare 4 Homicide To the Hospital or within 24 hours aff To the Funeral D completely filled in Blvd; Germantown, Maryland

1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCTOBER 25 2000 17385 mus 10 R TESORIERD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene Street Baltimore MD R Conley 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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			For State Registrar	State of Maryland		artment of He rtificate of D	eath	Reg.	211116	36007
	Physicia		1. Decedent's Name (First, Middle, Last, VETO JO		OWICZ			Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or L			4c. County of Death	, w 00p. 1
	Exam.	۲.	Manokin Mano	10		Princess	anne		Somers	et
	Funeral		5. Social Security Number 6. Sec	x 7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. a r	Date of Birth	9 Birth	place (State or Foreign intry)
	Director		002-01-2086 ^{1X}	1 M 2 □ F 88	Yrs.	Working Days	Ja	Month, Day, Yen. 3, 19.	18 New H	lampshire
	р. ,		Usual Residence of Decedent 10a. State 10b. County	100 Cib	, Town or Lo	-anti-n				10d. Inside City Limits
	show	_	10a. State 10b. County Maryland Somerse			rincess Ar	nne			1 ☐ Yes 2 ☑ No
	Be-t	cto						···		
	ith th	Director	10e. Street and Number			10f. Zip Code		10g.	. Citizen of What Cou	intry?
	s 23s	Funeral	11974 Edgehill Ter		6 10	218		Variatio	U.S.A.	ican Indian
	er de	une	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	5. 13.	If Yes, specify Cuban,	panic Origin? (Specify , Mexican, Puerto Rica	n, etc.)	Black, White	
0000	be filed within 72 hours after death with the Maryland tal Hyglene d other then "natural", or items 23a or 28e-t show event, the Medical Examinar must be a willfied at	by F	1 Never Married 2 Married 3 Widowed 4 XDivorced	1 XYes 2□No1943 If Yes, Give Year or Dates: 1046		1 ☐ Yes 2 ☐XNo	Specify:		SpecifyWhit	:e
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U		To B	Isodore Bernikowi	.cz			Grace Gra	cilia		
<u>يا</u>	and Men is marke		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address (Street an	nd Number or Rural Ro	ute Number, C	ity or Town, State, Z	ip Code)
Š	od 2 1th a 27 is		Barbara Dubray (N	iece)	56 N	ew Searles	Rd Nas	shua, N	.н. 03062	2
ก	s 1 ar		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of matory or other place,	Date	20	c. Location - City or 1	own, State
	Pages nent of int: If it		1 ▼Burial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)	Hemovai from State		aus Cemetery	1 .		Nashua, N.	Н.
baltillion	- 문문을		21. Signature	4	2:	2. Name and Address	of Facility			
Ď	Depar Impo any ir		Robert H. Bra	dshaw, Jr.	B 3	radshaw & 06 W. Mair	Sons Funer St Cris	al Home field.	MD 21817	7
г	4		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death						Approximate Interval Between
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	/Medical		disease or condition resulting in death)	a Due to (or as a consequ	uence of):	quemer	a seme	nua		6 90
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Š	the death cer y the attendin iched for use	an/N	230. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	incy I death 3[☐Ectopic pregnancy			23d. Date of deli	-
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ر ر	wrequires that the de been signed by the s should be detached	Physician/M	9 🗆 Unknown							
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r	The late has page	Con	Prumon	cia				performer	d? death? INo 1 ☐ Yes	2 No
V 1831	yeicien: The law requis certificate has been director, page 2 shoul	Be (25. Was case referred to medical examiner?				26. Place of Death (Cl	neck only one)		
	S S	일	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Other	4 Nursing Hottle			ify)
0	ding Phy h. After thi funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injury : Work?	at 28d.	Describe how	injury occurred	
UNISION	Attending r death. ector: After by the fune	atic	2 Accident investigation			M 1 7	es 2□No			
<u>"</u>	er de	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		reet, factory, office	28f.	Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
5	tel o	Cer								
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	cai		ysician: To the best of my kno liner: On the basis of examina						
	To the h within 24 To the F complete	Medicai	one)	and manner stated.						
	To the within To the comple	2	29b. Signature and title of certifier	7 00	0	29c. License			Date signed (Month	
			Rugora M	. Bellen	Mik	J 1 29	505	/	0-27-	2006
		4	30. Name and address of person who c							
			GREGORIO M. BEI			INABERRY	DR. SAL	ISBURY	Y, MD 2	1801
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa		1				
	Regist	ar	OCT 3 0 2	2006 Kleen	D.	goods		<u> </u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 0 0 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 Month **Physician** Braer November 15:24 PM Arnold /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A of Manuland Medical Center University Balhmore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. S. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea July 5, 1937 9. Birthplace (State or Foreign **Funeral ₩** 2 | F (NJ) New Jersey 577-48-2648 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits MD Prince Georges Laurel 1 ☐ Yes 2 KINo Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8310 Montpillar Drive 20708 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White Completed by 3 ☐ Widowed 4 🖾 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose Brodsky Oscar Joshua Braer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Ritchey - Sister 6825 Allview Drive Columbia MD 21046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State King David Memorial 5 ☐ Other (Specify) Falls Church VA 21. Signature of uneral Service Licensee 22. Name and Address of Facility Fleck Funeral Home Inc. Van 7601 Sandy Spring Road Laurel MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebral Edema /Medical Due to (or as a consequence of): Examiner HUDDKIC Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner pital or Attending Physician: The law requires that the death certificate be executed unra after death. each Director: Atter this certificate has been signed by the attending physician and filled in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by status post bile leak 1 Yes 2 No 3 Probably 4 Unknown Cholecystectom 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy pancreatitis gallstone perform .25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 ☑ Natural 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) S Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29c. License number 29b. Signature and title of certifier MD

DHMH 17 Rev 1/2001

State

Registrar

22.

South Green Street Ballmore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Meena V - 31. Date filed (Month, Day, Year)

NOV 14

MD

Registrar's Signate

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			For Stata Registrar		State	of Mai	ryland / í	Depa <i>Cer</i>	irtment of l	lealth a	and M		gien e Reg. No.	006	36009
1	Sec. at		1. Decedent's Name (First, I	Aiddle, La	st)							2. Date of De	ath	V	3. Time of Death
	Physici /Medic		Eugene J.	Co	lgan						k	October	Day 25	2006	2:12 P M
	Examin		4a. Facility Name (If not insti	tution, giv	e street and n	u <i>mber)</i>			4b. City, Town,	or Location of	of Death		4c. C	County of Death	1
		R	Bowie Healt							wie				ince Ge	orge's
ŀ	Funeral		5. Social Security Number 577–46–2610	6. 5	Gex IDXM 2□F	7. Age	(In yrs. last bii 71	rthday) Yrs.	Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			nplace (State or Foreign untry) .10
- Sir	Director		Usual Residence of Decede	nt		<u></u>	7.1					Apr.	.10		
	yland		10a. State 10b. Co	unty			10c. City, Tow	m or Lo	cation						10d. Inside City Limits
	e Mar	ctor	MD Pri	nce (George'	s		Boy	vie						1X Yes 2 □ No
	or 28	Director	10e. Street and Number						10f. Zip Code				10g. Citize	en of What Co	untry?
	death with the Maryland me 23a or 28a-f ehow f.must.be natified at		3012 Trinit	y Dr)715				USA	
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9500-612	d within 72 hours after death with the Marylan jiene. r than "netural", or iteme 23a or 28a-f ehow The Madical Examinar mast ke notified at	by F	3 □ Widowed 4 □ Divo		If Yes, G Year or	ive	,	1	☐ Yes 2XNo	Specify:			S	Specify: W	hite
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yland	be file nta! Hy od oth	Be	17. Father's Name (First, Min	_								(First, Middle,		iumame)	
	2 should be f and Mentat h ie marked of raumatic eve	2	Eugene C. 19a. Informant's Name/Rela				196	Mailin	g Address (Street			et Mill		Tour State 7	in Code)
Z	s 1 and 2 should be filed f Heelth and Mentat Hyg Item 27 is marked othe other traumatic event,		Frances L. C			use			Trinity			ie, MD.		0 71 5	<i>p</i> 0008/
ā,	f Hee f Hee item othe		20a. Method of Disposition		_		20b. Place o	f Dispo	sition (Name of natory or other pla			ate		ation - City or	Town, State
Ē	Page nent o nt: If		1 X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			n State	1		tion Ceme	· '	10/30	0/2006	Clir	nton, M	D.
Baltimore,	permit. Pages 1 and 2 Department of Heelth a Importent: if Item 27 is any injury or other tra		21. Signature of Funeral Se	vice Lice	nse	01	2	22	Name and Address	ess of Facilit	y Bea	all Fur		Home	715
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1.18 1.26	Physician		shock, or heart failure. Immediate Cause (Final	List only	one cause on	each line		1	- 4 (5) -					-	Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)		a Due to	(or as a	consequence		ance	<i>V</i> -					year
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ō	ding Physician: h. After this certific funeral director,	n: T	27. Magner of Death		28a. Date	· · · · · · · · · · · · · · · · · · ·	28b.	Time of	28c. Inju			8d. Describe			ny)
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)_	(10)		30. Name and address of pe	rson who	completed cau	ise of dea	ith (Item 23a)	(Type, I	Print)	la Ka	40	4. (-	?	601	half 21000
1	Sta	tę	31. Date filed (Month, Day,	ear)	32.	Registrar	's Signature		13010	14141	11261	170	any	7-1-145	רנטודם נוחי
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** COPELAND EDNA MAE 25, /Medical Oct 2006 5:30 Am 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Vill Montgomery Village Health Care Cen. Montgomery if Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1□ M 2□ F 28,1940 Washington D.C. Director 65 218**-**38-6599 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Dependment of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any fujury or other traumatic event, the Medical Evanricat must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ty⊈Yes 2□No Director Gaithersburg Md Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8118 Brink Road, 20882 Funeral U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ➡ No Specify: Specify: ፩ 3€Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Montgomery County Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George F. Stevenson Sr Louise Wims 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20882
Add Thorndike Dr. Gaithersburg, Md 19a. Informant's Name/Reletionship (Type Print) (Daughter) 9401 Thorndike Dr, Gaithersburg, Tanya Copeland Brown 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1 Surial 2 ☐ Cremetion 3 ☐ Removal from State All Souls Cemetery 10/30/06 4 ☐ Donation 5 ☐ Other (Specify) Germantown, Md 21. Signature of Funeral Service Uice 22. Name and Address of Facility Snowden Funeral Home P.A. 20850 23a. F. ntl. Enter the hiseas, or a mplications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a shock, or heart failure. List only one cause on each line. MdApproximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final disease or condition resulting in death) CARDIONMORKIN Examiner Due to (or es e consequence of): Examine MENTRICOLAR FIBRIMATION ending physician and use as the bunal-trensit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Lus STACIE Y 3 CH Q) X Physician/Medical Due to (or as a consequence of): certificate has been signed by the ettending irector, page 2 should be deteched for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 A No till Yes 2 MINO To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐ No 1 Inpatient 2 ER/Outpatient 3 DOA funerel 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Metural 5 Pending investigation efter death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 A Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Yeer) H0051280 10-30-06 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Anushiravan Dadgar, 9715 Medical Ctr Dr, #201, Rockville, MD M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 30 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 26 Month October 0 2006 Chick 11:32P M Peggy Ann 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth May 15, 1950 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months 1 ☐ M 2 🔀 F Mary and 56 218-54-8362 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Xyes 2 □ No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 750 Crows Court 21158 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2K☐ No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Olla Mae Collins Henry T. Davis Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy N. Chick/ daughter 2813 Hudson St. Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ *Cremation 3 ☐ Removal from State All County Cremation | 10/28/2006 | Sykesville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) weeks Due to (or as a confequence of): osteo myelitis Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ascular disease pheral Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 1 Yes 2 No known o death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Reside 2 No 1 ☐ Yes 27. Manner of Death

Physician /Medical Examiner

certificate be executed

Box 68760.

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Division or Vital Records,

or Attending Physician;

Physician

/Medical

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Department of H Important: If iter any injury or oth once.

Baltimore, Maryland 21215-0036

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3 ☐ Suicide

4 Homicide

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1 Certifying 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Marillay con	023203	Oct
30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) W. A. R. Ley G. RMC 670 (NC.	Charles St.	Bolto. Ma

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 3 0 2006

WSL 3

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}4 **Physician** Audrey Margretta Cramblitt 0ctober 2006 5:55A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. | 10, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 939 1□M 2**X**F 219-34-0853 67 Director Yrs Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow any Injury or other traumatic event, the Medical Emerit 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Maryland 1 ☐ Yes 2X No Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 560 Jasontown Rd. 21158 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married 1 Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) 12 cashier retail store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William R. Harvey Jr. Elizabeth Slade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth L. Cramblitt/ husband 560 Jasontown Rd. Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Methodist Cemetery 10/27/2006 Uniontown, MD 21. Significant Funeral Service Licensee 22. Name and Address of FacilityHartzler Funeral Home attarine 310 Church St. New Windsor, MD 21776 Part 1. Enter the disease, or complications that aused the death, shock, or heart failure. List only one cause or each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events nding physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 minths? 23d. Date of delivery 3 Ectopic pregnancy Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 1 ☐ Yes 2 ☐ No After this certification, 25. Was case referred to medical examiner?
1 ☐ Yes 2 → 100 Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 8b. Time of 28d. Describe how injury occurred atural 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Director: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 Homicide within 24 hours at To the Funeral D completely filled is 1 Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of pertifier 29d. Date şigned (Month, Day, Year) WIL Name and address of who completed cause of death (Item 23a) (Type, Print) 8 South Conterstreet wastmister, MD 21157 31. Date filed (Month, Da State Registrar 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 10 2006 14:23 20 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Montgomer 405pital 1055 If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 F Days 579-66-9846 54 **Director** 12-20-195 Washington D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. Cify, Town or Location ns 23a or 28a-f show must be notified at 10d. Inside City Limits Adel 1. Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 items 23a US.A Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, the Medical Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: Black Completed by 3 ₩idowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) Trivate Industra Data Entry 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Be lac Vina /ac 100 (Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dillard Sister-in-law 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐Removal from State Kiverdale Cremakony Riverdale, Maryland 10-27-06 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licenses Funeral 1813 Potomac AVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cirrhosis iver /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔁 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide within 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO 6 3343 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. IriNIA Ruban 1500 Forest Gle 1500 Forest Glen Koud IVINIA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

OCT 26 2006

32. Registrar's Signature

		•	For State Registrar	1040	St	ate of	Maryl		artmen ertificat				lental Hy	giene (06	36015
	1		1. Decedent's Name (First,	Middle, L	.ast)			<u>`</u>	1				2. Date of De. Month	ath Day	Year	3. Time of Death
€-	Physicia /Medic		Jacquel	ne				Pec	mon				Octobe		2006	8:07 P M
	Examin		4a. Facility Name (If not ins	titution, g	ive stree	t and nun	nber)		9		r Location			4c. Co	unty of Death	1
		9	Carroll H	OSPI	tal	Cent	ter		W	estr	nins	ter			Carro]	_1
6.	Funeral	T-S A	5. Social Security Number	6.	. Sex		7. Age (In)	rs. last birthda	/) If Under Months	r 1 Year Days	ff Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	th y, Year)	9. Birth Cor	nplace (State or Foreign untry)
	Director		214-28-0106		1 🗌 M	24.1		73 Yrs.					Mar 09	9 1933		PA
	pu 💌		Usual Residence of Deceder 10a. State 10b. C				10c	City, Town or	ocation							10d. fnside City Limits
	aryla sho	5			-11											1 Yes 2 3 No
	Ne M	Director		Carro)TT			wesu	ninste					10g. Citizen	of What Co	intry?
	leath with the Maryland ns 23s or 28s-f show must be ruttled at	ā	10e. Street and Number						101. 2.1						SA	artey.
	= 23 ≡	Funeral	617 Unionto	own I		Nas Dece	dent Ever i	nIIS 13	Was Dece	21	158	igin? (Sn	ecify Yes or No		Race - Ame	ican Indian
	0 5 5	'n.	11. Marital Status 1 Never Married 2	7 Married	_ A	Amed Fo	rces?		If Yes, spe	cify Cuba	an, Mexica	n, Puerto	ecify Yes or No Rican, etc.)		Black, White	
36	a o E	by	3 ☐ Widowed 4 🎇 Div	_	11	f Yes, Giv Year or Da	Θ		1 🗌 Yes	2 X No	Specify:	•		Sp	ecify: W	hite
5-0036	72 hours "naturel",		15. De	cedent's	Educatio	n		16a. Dec	edent's Usu	al Occup	ation			16b. Kind	of Business/	
715		Completed	(Specify only Elementary/Secondary (C			m <i>pietea)</i> Coflege (1	-4or 5+)	life	DO NOT u	se retired	auring mos d)	st of work	ing	Balt	imore	Gas and
212		E	12	,		, o			Super	viso	r			Elec	tric C	ÖO
b		Bec	17. Father's Name (First, M	fiddle, La	st)						18. Moth	er's Nam	e (First, Middle,	Maiden Sui	mame)	
lar	Mental Mental arked c	ToE	Sterling Ot	is 1	ravlo	or						Roma	ine Kid	ld		
Maryland 2121	2 should be and Menta is marked sumatic ev	•	19a. Informant's Name/Rel					19b. Ma	iling Addres	s (Street	and Numb	er or Rur	al Route Numb	er, City or To	wn, State, Z	ip Code)
	s 1 and 2 should if Health and Men tem 27 is marks other traumatic		Janeli R. Lev	ry/da	aught	er			Union				stminst			
Baltimore,	of He of He f Item		20a. Method of Disposition 1 → Burial 2 ☐ Crem	ation 3	□Remo	wal from	State 20	Db. Place of Dis cemetery, c	position (Na ematory or o	me of other plac			Date	20c. Locati	on - City or	Town, State
Ĕ			4 Donation 5 Ot			wai iioiii .		arrollt	on Ch	urch	Cem ¹	.0/28	/2006	Fin]	ksburg	, MD
alt	permit. Pag Depertment Important: I eny Injury o		21. Signature of Funeral S	ervice Lic	00000			I	71tts	nd Addre	eral	Home	and Ch	apel.	P.A.	
Ω	80559		1/1/2	~				4	12 Wa	shin	gton	Road	Westm	unste	MD.	21157
H			23a. Part1. Enter the disease shock, or heart failure	ase, or co	omplication	ons that cause on e	aused the d	death. Do not e	nter the mo	de of dyir	ng, such as	cardiac	or respiratory a	rrest,	•	Approximate fnterval Between
	Physician		Immediate Cause (Final disease or condition					al an	d roci	0.00	tary	for	lure			Onset and Death
R.	/Medical		resulting in death)	4	a. 1.	Due to (or as a cor	sequence of):	3 163	OHLO	VIOI 1	1.00	170010			
-	Examiner		Sequentially list conditions		b. S	Syste	mic	inflam	mouto	ry	respo	nse	syndi	rome		
	D =	ner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	or as a cor	sequence of):	1	l			1						
	rcuter nd Irans	Examiner	that initiated events	1	o. [Nete	stati	c cer	vical	cai	ncer					
0	be executed sician and burial-transit		resulting in death) Last			Due to (or as a cor	isequence of):								
9760	B % 6	lical			d											
68	0 0 0	Completed by Physician/Med	IF FEMALE:												1	
Вох	ath certif attending for use as	lan/	23b. Was decedent pregna in the past 12 menths			1 ☐ Live b		Fetal death	Ectopic p		у			23d	. Date of deli Month	very Day Year
	the a	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown			4∐Prøgn 9□Unkno	ant at time own	of death	Other (s	pecify)						
P.0	that the died by the detached	Ph	Part fl. Other significant c	ondition	s contribu	uting to de	eath but no	t resulting in the	underbing	cause ou	ven in Part		23e. Did 1	obacco use	contribute to	the cause of death?
ŝ,	ires ti signe	þ	Asiult march	a Clor	13/	Tuna	Tidi	1 1	nellite	11				Yes 2 M		obably 4 Unknown
orc	w requir been si should	etec	1	1	W2 11	· KI	ا ین بند ر		4	1/	11	CHISTO				
Vital Records,	ne law has b	nple	Anemia of	CHEO.	nic_	intla	mmod	on ans	mair	MIL	Tion		24a. Was auto		4b. Were au prior to death?	topsy findings available completion of cause of
H	sing Physicien: The n. After this certificate hi funeral director, page	Cor	Coronary art	erv	dise	ase	1/ Chr	onic Ki	dney c	tisea	KE		1 ☐ Yes	2 No	1 🗌 Yes	2 🗆 No
/ita	icien: Th certificete rector, pag	Be	25. Was case referred to n examiner?	nedical	Hosp	ital:				0#			h (Check only			
of	Physic this c	2	1 Yes 2 No			1 1/2		2 ER/Outpat				ursing Ho	ome 5 Resi			cify)
n C	Jing F	0	27. Manher of Death 1 Natural 5	Pending		(Mon	of Injury th, Day Yea	28b. Time Injur	, M	28c. Injui Woi	rk?]Yes 2.[INO	280. Describe	now injury o	scurred	
Sic	death death tor:	cat	3 ☐ Suicide 6 ☐	investiga Could no	t be	O. Diago	of Injune	At home, farm,			163 2	JINO	28f Location /	Street and N	umber or Ri	ıral Route Number,
Division of	or A after Direction by	Certification: To	4 Homicide	determin	ed ²	buildi	ng, etc. (S	pecify)	Street, ractor	ry, onice			City or To		LINDO, 0, 712	var riogio riginadi,
	To the Hospital or Attend within 24 hours after death To the Funeral Director:/		29a. Certifier	ertifying	Physicia	in. To the	hest of my	knowledge de	ath occurred	1 at the ti	me date a	nd place	and due to the	cause(s) an	d manner as	stated
	Hos 24 hc Fun	edical	(Check only 2 Me	edical Ex	caminer:	On the b	asis of examend.	mination and/or	investigation	n, in my	opinion, de	ath occur	red at the time,	date and pla	ice, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of	certifier			nor states.				se number			29d. Date s	igned (Monti	h, Dey, Year)
	⊢ 3 ⊢ δ			ton	M	D			1	D28	3462	L		Octo	ber a	24, 2006
	MIL		30. Name and address of			eted caus	se of death	(Item 23a) /T					Avenue			
	6		30. Name and address of Bos		no compl		11 3	Jospita	CP	nter	- U	lestr	ninster	, Mar	ylan	121157
(2)	Sta	to	31. Date filed (Month, Day				Registrar's S		,, 00	1				,		•
	Regist		OC"	126	3 200		Lower	J. K.	Brown	2						
	200	100					- 400 00		CO. S. C. S. C.	45						

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ORIGINAL

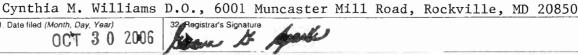
State of Maryland / Department of Health and Mental Hygien () 36016 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Nzundu Disasi 10:05 P^M October 0 26 2006 /Medicat 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery ear)
9. Birthplace (State or Foreign Country) Democratic Republic of Congo If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1XM 2□F 577-88-2199 61 July 4 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Director Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Democratic Republic of 20109 Green Run Court 20879 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🕱 No 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: If Yes Give Specify: Black 2 3 Widowed 4 Divorced Year or Dates: 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Transcriptionist Potomac Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Disasi Marie Nsele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mapata M. Mupeka / Wife 20109 Green Run Court, Gaithersburg, MD 20879 20b. Place of Disposition (Name of crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven October 31 4 □ Donation 5 □ Other (Specify) 2006 Silver Spring, MD 21. Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home, 10 East STUKR Deer Fark Drive, Gaithersburg, MD 20877 IRACY A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hepatocellular Carcinoma Due to (or as a consequence of): Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of Examiner Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death | Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 1 ☐ Yes 2X No 2 ER/Outpatient 3□ DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Tes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H0058032 Kinthia M Williams Do October 27, 2006

State Registrar 31. Date filed (Month, Day, Year) OCT 30

30. Name of diaddress of person who completed cause of death (Item 23a) (Type, Print)



Funeral

Director

r than "natural", or itema 23a or 28a-1 ahov the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene important: if item 27 is marked other than "natural", or itel may injury or other traumatic avent, the Medical Examples.

Physician /Medical

Examiner

attending physicien and for use as the burial-transit

ed by the a detached f

been signed by should be detacl

certificate

this After thi

Director;

To the Hospital or Attending Physician:

death.

within 24 hours a

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

the Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** elen lixon October 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death orchester HOSP. ambridge (general If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 214-34-895 1 □ M 2 🖫 F Months Yrs. Director 9,1919 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Dorchester Completed by Funeral Director Cambridg 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 2/6/3 Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married ŏ 1 Yes 2 No Specify: Black 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "na any Injury or other traumatic event (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Processing Line Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RUSSell James & FFie MeeKins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Road Cambridge 20b. Place of Disposition (Name of completry, crematory or other place) James 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Brisco Mem. Park 10/28/06 Cambridge, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY PLINERAL HOME P.A.
510 Washington St. Cambridge 21. Signature of Funeral Service Licensee 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final fice miz See **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LAYINO Trace 1-Sa uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an 212 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation Director: / 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after de To the Funeral Directo completely filled in by th To the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

47924

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAMBRIDGE MD 300 AURULA NOMAN

State Registrar

Medical

31. Date filed (Month, Day, Year) 7 OCT 2





			1 - For Registrar	State of M	aryland / Depa	artment of F	Health and <i>Death</i>		jiene (106	36018
			Decedent's Name (First, Middle, La	ist)	-			2, Date of Dea Month		Year	3. Time of Death
ı	Physici /Medio		Floyd	L.	E1	za		October		2006	1:11PM M
	Examir		4a. Facility Name (If not institution, gir			4b. City, Town, o		ath		unty of Death	
			34030 Clearfield				ke City			merset	
П	Funeral			Sex 7.Ag 1)X ÍM 2□F	e (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Day	r, Year)		polace (State or Foreign intry)
	Director		Usual Residence of Decedent		70			07/12/1	.930_	West	t Virginia
	yland how		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	e Ma	cto	MD Somerse	t	Pocomok	e City					1 ☐ Yes 2 ☑ No
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	intry?
	s 23s	ral	34030 Clearfiel		Fires in U.S. 120	2185		(04-)	14	USA	ion Indian
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Madical Examinar must be notified at	Funeral	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Armed Forces? 1 Yes 2	No			(Specify Yes or No- erto Rican, etc.)	14.	Race - Ameri Black, White,	
ဗ္ဗ	eal', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	•	1 ☐ Yes 2 No	Specify:		Sp	ecify: Wh	nite
Maryland 21215-0036	72 ho natur	Completed	15. Decedent's E (Specify only highest gi		(Give	dent's Usual Occup	during most of w	rorking	16b. Kind	of Business/Ir	ndustry
2	vithin ne. han	ldm	Elementary/Secondary (0-12)	College (1-4or	5+) /ife.	DO NOT use retire	d)				
2	filed v Hygie other t	ပိ	6 17. Father's Name (First, Middle, Las	none	51	teel Work		ame (First, Middle,		ehem Si	teel
and	d be f ental h red of	o Be	Ressie Elza	,				Arbogast	INICIONI SUI	marne)	
₹	should ind Men i marke umatic	2	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street		Rural Route Number	r, City or To	wn, State, Zi	ip Code)
Š	and 2 ealth a n 27 is		Cynthia Elza/Wife	2	PO Bo	x 82. We	stover.	MD 21871			
Je,	s 1 a of Hea item	1 3	20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place			20c. Locati	ion - City or T	own, State
Ē	Pages nent of I ant: If it		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Special		Beechwoo		. 1	02/2006	Princ	ess An	ne, Marylan
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examinat must be notified at once.	(21. lignature of Funeral Service Lice 22a. Part1. Enter the disease, or con shock, or heart failure. List only	MI MI	00295	Name and Addre Hinman Fu L1673 Som ter the mode of dyir			cess /	Anne,≀	Interval Between
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п	/Medical Examiner	725	()	Due to (or as	a consequence if):						
		ā	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consection of):						
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
oʻ	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):						
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9	ertifica ling pl	Med	IF FEMALE:	00 11							
.O. Box	The law requires that the death certifics ate has been signed by the attending phoage 2 should be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	У		23d.	. Date of deliv Month	very Day Year
S, D	uires that sign e d b d be deta	by Pł	Part II. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
ğ	w require been sig should b	edt						1 □ Y	es 2□N	o 3 🗆 Pro	bably 4 Denknown
Record		Completed						24a. Was a autops perform	sy med?_	4b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	oppsy findings available ompletion of cause of
/ita	y sician : Th nis certificate director, pag	Be (25. Was case referred to medical examiner?	Manadal		100		eath (Check only or	ne)		
of \	ys dis	ပို	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatio			4 Nursing	Home 5 Reside			ify)
uC	ding l	ion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year) 28b. Time o Injury	Wor	yat rk? Yes 2 ⊟No	28d. Describe h	ow injury oc	curred	
Division of Vital	Attending Physician: r death. ector: After this certifics by the funeral director. I	ficat	3 Suicide 6 Could not I	De Place of In	ury - At home, farm, str			28f. Location (S	treet and N	umber or Rur	ral Route Number.
<u>></u>	after Direction	Certification;	4 Homicide determined	building, et	c. (Specify)	201, 120101, 7, 011100		City or Town			
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exa	hysicien: To the best miner: On the basis o and manner st	of my knowledge, deat f examination and/or in ated.	h occurred at the tir vestigation, in my o	me, date and pla ppinion, death oc	ce, and due to the c curred at the time, d	ause(s) and late and pla	i manner as s ce, and due t	stated. to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	4. \		29c. Licens				gned (Month,	
			Dog.	M.D	•	05	7953	7	10/	30/2	1006
			30. Name and address of person who babulal Dan.	1.1 11801		Print) By Sale	sbush	, MD2	1801		
	Sta Registi		31. Date filed (Month, Day, Year)		ar's Signature	1 4					
			NOV 0 1	2006	Even St.	COMMENT					

1. Decedent's Name (First, Middle, Last)

VINCENZO FAMA

Oct.

2. Date of Death Month

25,2006

Year

Physician /Medical **Examiner**

4b. City. Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Charles BRYANS ROAD 2207 GARDEN LANE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 03-01-1959 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5 Social Security Number **Funeral** Days Hours Months 1 ∰ M 2 □ F 47 Italy 217-72-8137 Director Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County or 28a-f show or other treumatic event, the Medical Examiner must be nutified at 1 Yes 2 No Directo Bryans Road Maryland | Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20616 Itams 23a 2207 Garden Lane by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status e filed within 72 hours after. If Hygiene. other than "neturel", or Ital 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private Industry Truck Mechanic + 09 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be tealth and Mental Santa Donnia Orazio Fama 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health an, Important: If Item 27 is m. any Injury or other. Jennifer L. Fama/wife Bryans Road, Maryland 20616 2207 Garden Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 2 Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 10-28-2006 Washington National 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cedar Hill FH 4111 Pennsylvania Ave. Suitland,MD Mary Hedgmen M01374 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hepatocellular carcinoma Immediate Cause (Final **Physician** months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner years b Cirrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ysician and e burial-transit Chronic Hepatitis C infection requires that the death certificate be executed years that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending physical for use as the t IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 dunknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 2 -No 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 to Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 EN/Outpatient 3 DOA 2 this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital To the Funerel 1 🖫 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 24 within 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D19431 10-26-2006 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print)

Frank Ryan MD Road Suite 103 Fort Fort Washington, Maryland 20744 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 27 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene) 36020 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day **Physician** 1807016 MMON 28 2006 4c. County of Death /Medical 4a. Fecility Name (If not institution, giv 4b. City, Town, or Location of Death Examiner 146 5. Social Security Number Prince George Laurel anne Date of Birth (Month, Day, Y 01/28/ 7. Age (In yrs. last birthday) If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** Min Months Davs Hours 1 ☐ M 2 🕮 F 245-72-1780 96 Director South Carolina Usual Residence of Decedent death with tha Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits important: If item 27 is markad othar than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Medical Examinar must be notified at 1 Yes 2 No Md P.G. Landover **Funeral Director** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20785 1306 Eli Place USA 11. Marital Status 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 Yes 2√2 No Specify: Black Specify: ٥ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pamit. Pages 1 and 2 should ba filed within Dapartment of Health and Mental Hygiane. Important: If Item 27 is merkad othar than " Elementary/Secondary (0-12) College (1-4or 5+) Private Cafeteria Helper 5t.h 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Benjamin Rox Anna Black ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosa M. Lenzy Daughter 1306 Eli Place Landover, Md 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Reht Haven Cemetery 11/2/06 Wilson, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snead Mortuary Service, P.A. 21. Signature of Funeral Service Licensee 1409 Fairlakes Pl Ste B Mitchellville, MD 20721 Approximate Interval Between 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner DECOBITUS OLCER Examiner The law requiras that the death cartificate be axecuted attanding physician and for usa as tha burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Jas 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this cartifica completaly filled in by tha funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) u 14200 Laurel Park Dr.;Laurel,MD 20707 31. Date filed (Month, Day, Year) legistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1-For State Registrer Certificate of I		, 0	eg. No. 200	6 3602
Physic Medical Exam				2. Date of Deat Month November	h	3. Time of Death
· ·		beery hourse trianowski	City, Town, or Location of Dea		3, 2006 4c. County of Death	1309 hrs
•		Sinai Hospital	Baltimore			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 175–18–7734 1 M 2 X F 84 Yrs.	If Under 1 Year If Under 24 Months Days Hours M	11/29 8. Date of Birth	/1921 Solution (MM/DD/YYYY) 9. Bir Foreig	thplace (State or gn untry) PA
taryland 28a-f show any 1 at once.		Usual Residence of Decedent 10a. State	Hyattaville			10d. Inside City Limits 1 Yes 2 X No
farylan 28a-f sl	Director		10f. Zip Code	110	g. Citizen of What Cour	
with the Maryland ns 23a or 28a-f sho be notified at once.		5122 Crittenden Street	20781		US	A
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	Decedent of Hispanic Origin? (, specify Cuban, Mexican, Puer Yes 2 X No specify:	to Rican, etc.)	White, etc.	can Indian, Black, White
2 hours "natur Exam		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's during mos	Usual Occupation (Give kind of tof working life, DO NOT use re	of work done etired)	16b Kind of Business/I	ndustry
21215-0036 uld be filed within 72 Mental Hygiene marked other than c event, the Medical	Completed		Homemaker		Home	9
15-0 filed v al Hygi ed otha	Be Co	17. Father's Name (First, Middle, Last)		ne (First, Middle, M		
2121 ould be fi I Mental i marked	To B	George Jacoby 19a Informant's Name/Relationship (Type, Print) 19b. Mailing A	.ddress (Street and Number o	lle Airgo		Zin Code)
Multh allth		Rebecca Burner/Daughter 19 Fa:	irway Island,	Grasonvi	.11e, MD 2	1638
imore Pages 1 ment of H tant: If i		20a Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition crematory or other Metro Cre	ematory No	ov. 7, 2006	20c. Location - City or Baltimore	, MD
	4	21 Signature of Funeral Service icensee 22. Name Barri 495 23a of the Enter the disease, or complete is that caused the death. Do not enter the	ne and Address of Facility Canco & Sons, I Gov. Ritchie I	¬w∨. ∴⇔∨∈	rna Park I	AD 21146
Physician /Medical Examiner		failur List only one cause or eac line Atherosclerotic cardiovasc		or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
-xammer	(or condition resulting in death) Due to (or as a consequence of):	mai disease			
. Service	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
Į,	Examiner	(Clisease or injury that initiated events resulting in death) Last Use to (or as a consequence of):				
760, icate be executed physician and the burial transit		d				
760, ficate be e	dedical	#23a,27,perME,g861,	11/16/06 TT			
6876 certificat rding ply	sician/M	23b. Was decedent pregnant in the past 12 months?	death 3 Ectopic pregr	nancy	23d. Date of delivery Month D	ay Year
that the death certifulate by the attending detached for use as	ysic	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other 9 Unknown	(Specify)			
, P.O.	by Phy	Part II. Other significant conditions contributing to death but not resulting in the und	arlying cause given in Part I.		acco use contribute to the	
ords, F w requires is been sign should be				1 Yes	2 No 3 Proba	
cor e law re e has be	Completed			autopsy perform	y prior to co	opsy findings available ompletion of cause of
tal Rec cian: The l certificate l	ပ္ပ	25. Was case referred to medical	26.Place of Death (Check	1 ✓ Yes 2		2 No
Vital hysician: this certif	ĕ	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3	Other:		esidence 6 Other:	
Division of Vital Records, talor and tending Physician: The law requirers after death al Director: After this certificate has been sited in by the funeral director, page 2 should be	l iii	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)		28d. Describe ho	w injury occurred	
isior Attender er death rector:	icati	2 Accident Investigation 28e Place of Injury - At home form street 6	1 Yes 2 No	29f 1 applies (Ct	and and Number	
Div spital or ours aft seral Di	Certification	3 Suicide 6 Could not be determined (Specify)	solory, office building, etc.	or Town, Sta	reet and Number or Rura te)	al Route Number, City
Division of Vital Records, P.O. Box 68 to the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated	at the time, date and place, an, in my opinion, death occurred	d due to the cause(at the time, date ar	(s) and manner as starte	cause(s)
F > F 3	ž	29b Signature and title of certifier	29c. License number		29d. Date signed (Mont	
	-	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		November 4, 2006	3
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Stre	eet, Baltimore, MD 2120	1		
St	ate	31 Date filed (Month, Day, Year) 32 registrar's Signature	•			
Regist	EII	NUV 0 8 2006	<u></u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 per doc 9861 11-14-06 State of Maryland / Department of Health and Mental Hygiene 36022 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GROVES ELIZABETH UCTOBER VIRGINIA 2:35 AM 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOPKINS HOSPITAL JOHNS BAUTIMORE THE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year Min. Apr. 26, 1941 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 N 212-38-7342 Ν'nο 65 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12005 N. Branch Rd. 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1□ Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Edward Lewis Elizamae Rankin Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12005 N. Branch Rd. Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) Elisworth Groves husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Davis Memorial Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 10/18/2006 Cumberland 4 Donation 5 Other (Specify) MD 21. Signature of Funeral Service Licers 22. Name and Address Funeral Home, PA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Be Completed by Funeral Director

ဂ

MD

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturat", or items 23a or 28a-1 show pinjury or other traumatic event, the Medical Examinar must be notified an once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 ed by the detached beer signed to should be detailed within 24 hours after de To the Funeral Directo completely filled in by th

110000	110 CVC	10	<u> 8 Virginia Aver</u>	<u>lue: Cumberla</u>	nd, MD 215	502
23a, Panyl. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea	th. Do not enter the mod	e of dying, such as cardi	ac or respiratory arrest		Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	. SEPSIS					Onset and Death
	Due to (or as a conse		Francis -		A . V	7 44 4 4 77 4 4
Sequentially list conditions,		PPRESSION -	from RENA	IL TRANSPL	ANI	7 MONTH
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):				
that initiated events resulting in death) Last	c. Due to (or as a consec	Cupros of).				
	Duo 10 (01 as a conse	quence or).				1
•	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ™ O 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 6 9 ☐ Unknown	al death 3 □Ectopic pre	egnancy ecify)		23d. Date of de Month	blivery Day Year
Part II. Other significant conditions co		sulting in the underlying ca	ause given in Part I.			o the cause of death?
				24a. Was an autopsy performed	? prior to death?	utopsy findings availab completion of cause of
25. Was case referred to medical			26. Place of De	eath (Check only one)	101	2 2 140
examiner? 1 ☐ Yes 2 ☐ Yo	Hospital: 1 Alnpatient 2	ER/Outpatient 3□ DO	! Oth an	Home 5 ☐ Residence	6 ∏Other (Spe	acify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	Bc. Injury at Work? 1 Yes 2 No	28d. Describe how i		,
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory, fy)	office	28f. Location (Stree City or Town, S	and Number or R ate)	ural Route Number,
29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	rsician: To the best of my known of the basis of examination and manner stated.	owledge, death occurred a ation and/or investigation,	at the time, date and place in my opinion, death occ	e, and due to the cause curred at the time, date	e(s) and manner a and place, and du	s stated. a to the cause(s)
29b. Signature and title of certifier		29c.	License number	29d.	Date signed (Moni	th, Day, Year)
	MEPICAL DOCTOR	9	E5-000	00	TOBEIZ 19	7 10/-

State Registrar AIMA AHONKHAI THE JOHNE HOPKINS HOSPITAL, GOO NOKTH WOLFE STLEET, PAUTIMOKE MALYLAND 21287
31. Date filed (Month, Day, Year)
32. Registrar's Signature 10114

ss of pers who compled cause of death (Item 23a) (Type, Print)

		State of Marylai 1- Stete Registrar	nd / Depa		alth and M	ental Hygi		36023
Physic /Med		Decedent's Name (First, Middle, Last) Clarence Green				2. Date of Death Month October	Day Year 23,2006	
Exami Funeral Director	ner	4a. Facility Name (If not institution, give street and number) Arcola Health&Rehab Cente 5. Social Security Number 5.79-18-6562 6. Sex 7. Age (In yrs 1 M 2 F	s. last birthday)	4b. City, Town, or L Silver S If Under 1 Year Months Days	pring	8. Date of Birth (Month, Day, Aug 04	Montgom Year) 9. Birt Co 1923 DC	
Р		10210111	city, Town or Lo	ocation Spring				10d. Inside City Limits 1 XYes 2 No
with the 3a or 28a	i Direc	10e. Street and Number 901 Arcola Ave		10f. Zip Code 20902			Og. Citizen of What Co USA	ountry?
ince, intenty intention 2.12.15.0000 s. 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "netural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notitied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 National Process 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ② No	panic Origin? (Spe Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B1	e, etc.
within 72 hou ene. then "neture he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		edent's Usual Occupation of work done du DO NOT use retired)	on ring most of workin		16b. Kind of Business	
lai y lailu 6 16.	To Be Co	12th 17. Father's Name (First, Middle, Last) Clarence Green		V		inkney		
ie, Mai s 1 and 2 sho f Health and item 27 is mu other traum		19a. Informant's Name/Relationship (Type, Print) Tavia Page (Daughter) 20a. Method of Disposition	300	ing Address (Street an Kings Cr cosition (Name of amatory or other place)	oft Che	erry Hi	. 11 , NJ 08 20c. Location - City or	034 Town, State
Dallingle, Mapper I and 2 Department of Health a Importent: If item 27 is any injury or other transones.		1 12 Burial 2 Cramation 3 Hemoval from State	ncoln	Mem Cem	OCT 2		Suitland	Maryland 20011 NW WashD
Physician /Medica Examine	Examiner	23a. Part1. Englithe disease, or complifation and to used the decisions, or heart failure. List only rise cause on each line. Immediate Cluse (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to ammodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions). Due to (or as a consequence of the conditions). Due to (or as a consequence of the conditions).	equence of):			r respiratory arre	ost,	Approximate Interval Between Onset and Death
death certifica e attending ph	Physician/Medical	d	tal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	iivery Day Year
w requires that the been signed by the should be detached	ğ	Part II. Other significant conditions contributing to death but not re	sulting in the u	underlying cause giver	in Part I.		oacco use contribute to os 2 □ No 3 □ Pi	o the cause of death? robably 4 ⊠Unknown
The law recate has bee	Completed					24a. Was ar autops perform 1 🗆 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of 2 No
Physician: This certifical	Be	25. Was case referred to medical examiner?		Other	26. Place of Death		e) ence 6 ⊡Other <i>(Spe</i>	mittel)
_ 6 _ 9 e	ation; To	1 Yes 2 Xo 1 Independent 2 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	ER/Outpatie 28b. Time o Injury	of 28c. Injury a	at 2		w injury occurred	City)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral or the funeral o	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury : At building, etc. (Special Countries)		treet, factory, office		28f. Location (Sti City or Town	reet and Number or R. n, State)	ural Route Number,
ie Hospit 24 hour ie Funer sletely filts	edical	29a. Certifier (Check only one) 1 X Certifying Physicien: To the best of my king the control of the basis of examinant manner stated.	nowledge, dea nation and/or in	ath occurred at the time investigation, in my opi	o, date and place, a nion, death occurr	ed at the time, da	ate and place, and due	e to the cause(s)
To the within 2 To the complet	Ř	29b. Signature and title of caeffier		29c. License D09834			od. Date signed (Mont october 2	
-(3)		30. Name and address of person who completed cause of death (It	em 23a) (Type					
9	tate	Barry RosenBaum 3720 Fara 31. Date filed (Month, Day, Year) 32. Registrar's Sig	agut nature	Ave Ke	ensingto	md.	20895	
Regis		OCT 3 0 2006 Fee &	Sperk					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. UU6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 25 222 worth 2006 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner Burrie WASh Med Glen If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min. 1፟፟M 2□ F Yrs 23 Director 429-55-2019 5-16-1983 Arkansas Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show the notified at 1 Yes 2 □ No Directo Maryland | Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a any injury or other traumatic event, the Medical Evantine mantals. 468 Glen Mar Road, Apt. C3 Funeral 21061 U.S.A. 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specify: Specify: White δ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Laborer Private Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kenneth M. Hamilton Kathy Lynn Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gaylon P. Hamilton - Uncle 568 Rock Creek Road, Hardy, Arkansas 72542 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
☐ Burial 2 □ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Turkey Pen Cemetery 10/30/06 Hardy, Arkansas 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Priysician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due V (or as a consequence of): Examir physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Due to (or as a consequence of) Se esn signed by the a defected f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificete has 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No funerel director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ဥ 1 X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Se 1 ☐ Yes 2 No 10/25 UNK Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide tome GleN Burvie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as Med Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed filled in by

death with the Maryland

altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics

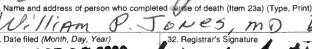
31. Date filed (Month, Day, Year) State OCT 27 2006 Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

edical



Deputy

29c. License number

29d. Date signed (Month, Pay, Year)

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygienes For State Registra 36025 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 27, 2006 ROSALINE GOLDIE HENDLER 2:10 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing Center Montgomery Rockville er 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 14, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🖔 F Months Days Hours Director 378-34-8337 70 Yrs 1935 Michigan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or than "natural", or Itame 23a or 28a-1 show the Medical Experimentment be notified at 10d. Inside City Limits Director Md. 1 ☐ Yes 21 No Montgomery Clarksburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 12824 Clarksburg Square Rd. #302 20871 United States by Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r College (1-4or 5+) 5+ Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morris Refson Esther Rockow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra M. Theresa Bourbon (Guardian) 1700 Rockville Pike Suite400 Rockville, Md. 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Oct. 30, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Pk 2006 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications have caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner thrieve urc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery atter 3 Ectopic pregnancy ō Month 4☐Pregnant at time of death Day Year P.O. 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 KNo 24a. Was an page 2 autopsy certificate 1 Yes 2 No To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury within 24 hours efter death. To the Funeral Director: A 1 Tyes 2 TNo 2 Accident filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 90 D62435 October 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Dr. Dr. Sayed Elsayyad M.D. Rockville, Md. 20850 31. Date filed (Month, Day, Year) ♣egistrar's Signature State OCT 3 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygien@ [] [] 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 21, October 2006 2:50 Mildred Mae Hampton /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges 8900 2nd Street Lanham If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 21, 19 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖾 F 90 Yrs. 1916 Director 224-16-8312 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rel', or items 23a or 28a-f show Examiner must be notified at 1 AYes 2 No Directo Prince Georges Maryland Lanham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8900 2nd Street 20706 United States death \ Completed by Funera 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status iled within 72 hours after 1 Tes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced White "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 12 should be filed with and Mental Hygien 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Susan Frances Rhodes William Peter Hanger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 are Health ar Fonda Wise / Daughter 8900 2nd Street; Lanham, Maryland 20706 permit, Pages 1 and Department of Healt Important: If item 2' any injury or other Once. other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 10/25/2006 Suitland, Maryland Cedar Hill Cemetery 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 21. Signature of Fulleral Service Licensee 1040 Kockville Pike; Kockville, Maryland 20852 23a. Part1. Uniter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Advanced Senile Demention Immediate Cause (Final Many yrs **Physician** disease or condition resulting in death) /Medical Examiner Zhe, mers Many yrs. Sequentially list conditions, if any, leading to initial diato cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for as a consequence of Examiner death certificate be executed use as the burial-tran and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Dther (specify) P.O. 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Hyperlipidemia, Hypothyroidism, 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should Artery Disease, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Degeneration 1 ☐ Yes 2 ☐ No Macular 2 No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. • Funerel Director: A 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 24 ho

To the Fune
completely fi (Check only one) 29c License number 29d. Date signed (Month, Day, Year) 10/24/06 1) 31001 7500 Greenway Catr. Dr. #430 completed cause of death (Item 23a) (Type, Print) Greenbell, MD Kewi 7 Z, MD 31. Date filed (Month, Day, State 30 Registrar

State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month 0735 A M B. Hoffman 2006 Irainia 10 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury
Hadar 1 Year If Under 44 Hrs.
Min. Coastal Hospice At the
5. Social Security Number 6. Sex Wicomico 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 27, 1922 Birthplace (State or Foreign Country) **Funeral** 1□M 2점F Days Months Hours 216-14-2282 84 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or itama 23a or 28a-f ahow the Medical Examinar must be notified at 1⊠Yes 2□No Director Sussex Delmar 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 305 Delaware Avenue U.S.A. 19940 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours efter Hygiene. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No <u>م</u> Specify 3 2 Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Home Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: if itam 27 is marked other t jury or other traumatic avant, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sewell Rayne, Sr. Mollie Driscoll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Hoffman, Sr. (Son) 12408 Midpointe Drive Riverview, FL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: if any injury o 4 ☐ Donation 5 ☐ Other (Specify) Oct. 27, 2006 Delmar, Delaware St. Stephens Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 E. Grove Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. moit Delmar, DE 19940 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Canill **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12/months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → 0 24a. Was an 1 ☐ Yes No No Be funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 12 Inpatient 1 ☐ Yes > No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Alter 5 Pending Injury **™**Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D26278 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Box 1733 Solish, MD 21802 E. Coreall Hospine 31. Date filed (Month, Day, Year) 32. Pagistrar's Signatur

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Baltimore,	permit. Pages 1 Dapartment of h Important: if its any injury or ot once.		1 X Burial 2 ☐ Cren 4 ☐ Donation 5 ☐ C					matory or other pla 1 Cemeter		10/31	/06	Hill.	side	, Ne	w Jersey
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	p ti	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying	te 🕹	Due to (or as	a conseq	uence of):								
	and and ii-tran	каш	Cause (Disease or injury that initiated events resulting in death) Last	1	cDue to (or as	a consen	neuce of):								_
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ıd	w requira baan sig should b		-								10	Yes 22	No 3	Prob	ably 4 □Unknown
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sic	Attanding r daath. sctor: Atta	icat	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigation Could not be		iunz - At h	ome farm ct	reet, factory, office	195 2		of Location /	Street and	Number	or Rura	l Route Number,
Division of Vital Records,	aftar Dirac In by	Certification;	4 Homicide	determined	building, e			reer, ractory, office			City or To	wn, State)	realibor	0771072	, riodio ridinaor,
	Hospital		29a. Certifier	ertifying Ph	ysician: To the best	of my kno	wledge, deat	h occurred at the t	me, date	and place, ar	nd due to the	cause(s)	and manr	ner as st	ated.
	To the Hospitei or Attend within 24 hours after death To the Funeral Director: /completely filled in by the fi	Medicai	(Check only 2 N	ledical Exam	niner: On the basis of and manner st	of examina	tion and/or in	vestigation, in my	opinion, o	death occurred	at the time,	date and	place, an	d due to	the cause(s)
	To tha within 2 To the complat	Me	29b. Signature and title of	certifier	00	1		29c. Licen	se numbe	er	_	29d. Date	signed (Month,	Day, Year)
	, 0		120	12		1,2	n	0	26	270	5	10	- 0	26.	-06
	CAN		30 Name and address of	person who	completed cause of	death (Item	n 23a) (Type,					1)		Α.	.0.0
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 86 James Jackson 10 /Medical County of Death acility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Regional Medical Center Salisbury Wicomics Peninsula Birthplace (State or Foreign Country) If Under 1 Year | If Under 6 Sev 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days 1 XM 2 ☐ F 215-18-2889 80 Maryland Director 1926 Oct. Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1**X**Yes 2 No MD Wicomico Salisbury Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 351 Deers Head Hospital Road 21801 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: unknown 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 TXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: black 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown 8 and Mental Hygie is marked other t permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other transmitted. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Bradford 1504 Riverside Drive, Salisbury, MD p.r. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Salisbury Crematory 4 Donation 5 Other (Specify) 10/27/06 Salisbury, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee R 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 1 day disease or condition resulting in death) assiration Meum MI a /Medical Due to (or as a consequence of): Examiner 1/aus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be execute and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the l nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ate has been signed by the atte page 2 should be detached for i Month in the past 12 months? Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Tes 2 No 3 Probably 4 onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 1√10 Attending Physician: To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 2 ER/Outpatient ဥ 1 🗌 Yes 1 Inpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of pertifier

31. Date filed (Month, Da

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Silvia

2006

DHMH 17 Rev 1/2001

Jr ms

32. Registrar's Signature

29c. License number

30853

Regional Medica

29d. Date signed (Month, Day, Year)

			1 - For State Registrar		State of M	/larylan				lealth a Death	and Mo	-	gienę Reg. No:	/ H H H	6	360	30
			1. Decedent's Name (First, Mic	ddle, Last)								2. Date of De Month	ath Day	Υ,	ar	3. Time o	of Death
	Physici /Medic		Eu1a		R.		Low	ther				Octobe	′			10:35	5 A M
	Examin		4a. Fecility Name (If not institu	tion, give s	treet and numbe	or)		4b. Cit	, Town, o	r Location o	of Death		4c.	County of I	Death		
и			Holy Cross Hosp	ital				Si	Lver S	pring			Mor	ntgamer	У		
	Funeral Director		5. Social Security Number 235-36-0464	6. Sex 1 □	M 2 F	Age (In yrs. 82	last birthday) Yrs.	If Und Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da July 25,	y, Year)		Coun	lace (State try) Virgin	
- 10	pu &		Usuel Residence of Decedent 10a, State 10b, Cour	ntv		10c. Cit	y. Town or Lo	cation							1	Od. Inside C	City Limits
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	Ne N	ect	Maryland Prin	ce Geo	orge's	(ollege	1	ip Code				10a Citi	zen of Wha	t Coun	itry?	
	with the	늅						101. 2		V.O			rog. Oiti	USA		, .	
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36	4 within 72 hours after death with the Maryland liene. r then "natural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ N 3 ☑ Nover Married 2 □ N	arried	12. Was Deceder Armed Force: 1 ☐ Yes 2X If Yes, Give Year or Dates	s? ∑ No		f Yes, sp	ecify Cuba 2 2 No	Specify:	n, Puerto F	cify Yes or No Rican, etc.)		Black, Specify:	White,		
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d	Hygi other		17. Father's Name (First, Midd	le, Last)						18. Mothe	er's Name	(First, Middle	Maiden				
an	ould be i Mental I Marked o	To Be	Arlie Waitman	Short	-						Lucill	le Maxso	n				
<u>Z</u>	d 2 should be filed th and Mental Hyg ?7 is marked othe traumatic event,	-	19a. Informant's Name/Relation				19b. Mailir	ng Addre	ss (Street	an <i>d Numb</i> e	er or Rurai	Route Numb	er, City o	Town, Sta	te, Zip	Code)	
Maryland 21215-0036	and 2 selth ar n 27 is		James Lowther / S	on			12208	Nort	hwood	Drive	Upper	Marlbor	o, Man	yland	207	772	
as a	4 9 E E		20a. Method of Disposition			20b. F	Place of Dispo	sition (N	ame of	-01	D	ate	20c. Lo	cation - Cit	y or To	wn, State	
9	ages ant of t: If i		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		emoval from Sta	te i	nington	-			0/31/2	2006	Suit	Land, N	hrv:	land	
Baltimore,	permit. Pages 1 Depertment of H Important: If Ite any injury or ot once.		21. Signatur Funeral Servi		e /	1	22	. Name	and Addre	ss of Facilit	ly _						
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O. Box 6	death certifi e attending id for use as	/sician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2	3c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	Ideath 3□	Ectopic Other (pregnancy specify) _	,			1	3d. Date o Month	f delive	•	Year
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rd	w require been si should t											10	Yes 23	[]No 3[Prob	ably 4 □	JUnknown
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ital	ician: Th certificete rector, pag	Se C	25. Was case referred to med	ical						26. Place	of Death	(Check only	one)				
>	Physician: this certific rel director.	To B	examiner? 1 ☐ Yes 2 ဩ No	Н	lospital: 1 🔀 Inpa	atient 2	ER/Outpatier	nt 3□ (Oth	er: 4 🗆 Nu	ırsing Hon	ne 5 ☐ Resi	dence (Other (Specify	1)	
ion of	After fune		27. Manner of Death 1 ☑ Natural 5 ☐ Per 2 ☐ Accident inve	iding estigation	28a. Date of Ir (Month, L	njury Day Year)	28b. Time o Injury	M	28c. Injur Wor 1 🗆	yat k? Yes 2 □		8d. Describe	how injur	y occurred			
Division	al or Attandi s efter death. Il Director: A d in by the fu	Certification:		ild not be ermined	28e. Place of building,	Injury - At he etc. <i>(Specif</i>		eet, facto	ory, office		2	8f. Location (City or To			or Rura	I Route Nur	mber,
	To the Hospital or A within 24 hours efter To the Funeral Dire completely filled in b	edicai (sician: To the be nar: On the basis and manner	of examina											s)
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R	(15)		30. Name and address of pers Daya Sharona						Silv	er Sn	rino	, Maryl	land	2091	0		
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		For Stete Registrar		State	of Ma	rylan				lealth a Death	and N	lental Hy	giene Reg. Na	006	5	36031	
Physici	. ^ 	1. Decedent's Name (Fire	st, Middle,	Last)								2. Date of De Month	Day		ear	3. Time of Death	
/Medi		Edna Ma		yon								Octob	7			5:00a M	
Examir	er	4a. Facility Name (If not a 17811 Mer			number)				, Town, or ccoke	Location o	of Death			County of I		0.000	
		5. Social Security Number		S. Sex	7. Age	(In vrs.	last birthday)		er 1 Year		24 Hrs.	8. Date of Bir		rince			n
Funeral Director		250-90-60.		1 □ M 2 □ X		1	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Aug. 28	y, Year)	35 Sc	Coun	lace (State or Foreign stry) n Carolina	ĺ
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arylar	_	10a. State 10b	. County			10c. City	y, Town or Lo	cation							1	0d. Inside City Limits 1 X Yes 2 □ No	
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eath	Funeral Director	17011 FIET	THO D		ecedent E	ver in U.	S. 13. 1	Was Dece			gin? (Sc	ectv Yes or No		4. Race -			
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if y fattice Z is 200000 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "neturel", or items 23s or 28s-f show umatic event, its Madisal Examinar must be multiled at	ြ	19a. Informant's Name/F					19b. Mailir	ng Addres	s (Street			al Route Numb	-	Town, Sta	te, Zip	Code)	
ING 2 IIII at 27 is r treu		Carolyn Ty	son	/ Daugh	ter		9319	Font	ana	Drive	Lar	nham, Ma	ryla	nd 20	0706)	
politically in the Marylan of the Committee of the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Madical Examinar manks notified at once.		20a. Method of Disposition				20b. P	lace of Dispo	sition (Na	ame of other plac	(e)		Date	20c. Loc	cation - Cit	y or To	wn, State	T
Page Page net: M		1 🎇 Burial 2 🗌 Cre 4 🗎 Donation 5 🗎			om State		surrec	-			11/0	04/2006	Cli	nton,	Md	•	
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ted	nine	Sequentially list condition if any, reading to immedicause. Enter Underlying Cause (Disease or injury	late	Due	to (or as a	conseq	uarica ory.										
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Attending Physician: The law requires that the death certificate be executed in death. •ctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be deteched for use as the burial-transit.	call			d													
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th certification of use	an/N	IF FEMALE: 23b. Was decedent preg in the past 12 month		23c. If yes, 1□Liv	outcome o			Ectopic	pregnancy				2	3d. Date o	f delive	ery Day Year	
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ysici ysici is cer direc	To B	examiner? 1 ☐ Yes 2 ☐ M6		Hospital: 1	□Inpatier	t 2 🗆	ER/Outpatier	nt 3 🗆 C	Oth Oth	or ·		ome 5 Resi		Other (Specify	()	
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in Title	Certification:	3 Suicide 6 (4 Homicide	Could no determin	ad 286. Pt	ace of Inju- uilding, etc.	ry - At ho (Specify	ome, farm, str /)	eet, facto	ry, office			28f. Location (City or To			or Rura	l Route Number,	
spitel		29a. Certifier 1P7	Certifying	Physician: To	the best o	f my kno	wledne deatl) OCCUTO	d at the tin	ne date an	nd place	and due to the	cause(s)	and manne	ar as si	lated	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 36032 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Catherine Myers 2006 1/5 AM DOTOBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Harford General Hospital Havre De Grace | House 1 Year | Hours | Min. | 7 Manth. | Pay. | 1 Year | 1 Year | 1 Ones | Min. | 7 Manth. | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year | 1 Year 9. Birthplace (State or Foreign New York 7. Age (In yrs. last birthday) **Funeral** 134-30-8302 1 M 2 XF 68 Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Itams 23a or 28a-1 show the Madical Examiner must be notified at Suffolk N.Y. Deer Park Yes 2 No Funeral Director 601 Carlls Straight Path 10g. Citizen of What Country? 10f. Zip Code 11729 USA 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō White Maryland 21215-0036 1 ☐ Yes 2 No Specify: β 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Itam 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Catherine O'Gorman John Cody 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Manning Drive East Northport, New York Robert E.Cody/Brother 0 or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department o Important: If any Injury or once. 11/03/2006 Huntington Station, 5 Other (Specify) St.Patrick Cem. 7 PHITEIPADSKINALDI FUNERAL SERVICE, P. A. 21. Signature of uneral Service Licens 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Orterioschertic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical ettending physical for use as the b 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ma 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed: 1 ☐ Yes 2 YNo 1 ☐ Yes 2 XNo atherine 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

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After this certification funeral director, p deeth. within 24 hours after deeth To the Funeral Director: , completely filled in by the f

4 Homicide 29a. Certifier (Check only one)

2 Accident

3 Suicide

5 Pending

investigation

6 Could not be

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

00014206 MA DME OCTOBER 29, 2006 Hoted cause of death (Item 23a) (Type, Print) 4 CHURCH VILLE Rd BEL AIR, NO 21015

31. Date liled (Month, Day, Year) State 30

Name and address of person wild

UKNA, MY DAE

28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 6 36033 For State Registrar Certificate of Death Rag. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician OCTOBER** 2006 11:59 26 ROBERT BRUCE MEADE /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1713 BROADLEE TRAIL ANNAPOLIS ANNE ARUNDEL If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday If Under 1 Year 5. Social Security Number **Funeral** Days 1**X**M 2□ F Yrs Director 86 10/13/1920 MD 245-18-7431 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f ehow of Health and Mental Hygiene Item 27 is marked other then "naturel", or iteme 23a or 28e-f ehov other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Directo MD ANNE ARUNDEL ANNAPOLIS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1713 BROADLEE TRAIL 21401 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced WHITE 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 SUPERINTENDENT / B&O POLICE RAILROAD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill rement of Health and Mental Hitem 27 is marked of Be ROLAND OCTAVUS ANNA NORFOLK 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARIE VALERIO / NIECE 1751 BROADLEE TRAIL, ANNAPOLIS, MD 21401 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages:
Department of H
Importent: If ite
eny in|ury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION 10/28/2006 STEVENSVILLE, MD 21. Signature of Funeral Sepice Licensee FELLOWS, HELFENBEIN & NEWNAM CREMATION & FUNERAL 10 CARE, 814 BESTGATE RD., ANNAPOLIS, MD 21401 ee, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a, Part 1, Enter the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, tary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hard transmit. Due to (or as a consequence of) Box 68760 Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how intury occurred 5 Pending 1 TYes 2 No investigation М 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 41955 eccation MY 31. Date filed (Month, Day, Year) State Registrar

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	/Medic	al		McKenzie			_		10	Octobe		2006 unty of Dea	
	Examin	er	4a. Facility Name (If not institution, give si					Location o	Death				
			4819 Lynn Burke R		la a di bilado alo col		nrov:	ia If Under:	24 Hrs.	8. Date of Birth		ederi	C.K. thplace (State or Foreign
	Funeral		5. Social Security Number 6. Sex	7. Age (<i>In yrs</i> . M 2□F 66	iast <i>birtnd</i> ay) Yrs.	Months		Hours	Min.	May 20,	Year) 1940	Pe	nnsylvania
	Director	-	215-36-8428 Usual Residence of Decedent	- 00						riay 20,	1740	10	misyrvania
1	D		10a. State 10b. County	10c. Cit	y, Town or L	ocation							10d. Inside City Limits
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	9ain	era		2. Was Decedent Ever in U	.S. 13.	Was Deci	edent of H	ispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14.		erican Indian,
_	ite it	S	1 Never Married 2 Married	Armed Forces? 1 P1Yes 2 □ No						Rican, etc.)		Black, Whi	_{te, etc.} White
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ڄ	etura Se la	9	15. Decedent's Educ	ation	16a. Dece	dent's Us	ual Occup	ation during mos	t of work	na	16b. Kind	of Business	/Industry
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ğ	ethe ent,	Bec	17. Father's Name (First, Middle, Last)					18. Mothe	ar's Name	(First, Middle,	Maiden Su	mame)	
Maryland 21215-0036	d de participa de	ToE	Howard W. M	cKenzie					era	Wilbu			
<u>2</u>	Shot and A		19a. Informant's Name/Relationship (Typ							I Route Numbe			
Σ	elith c		Wayne L. McKenzie							, Monr			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the marylan Department of Heelin and Mental Hygiene. Department of Heelin and Mental Hygiene. Introprient: If term 27 is marked other than "neturel; or iteme 23a or 28a-1 ehow eny injury or other treumatic event, the Mudical Examinat must be notified at once.		20a. Method of Disposition 1 Burial 2 Kremation 3 R	arrangementeb.	Place of Disp cemetery, cre	osition (Namatory or	ame of other plac	ce)		Date		•	r Town, State
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ĭ≚	or Attendation death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, s ify)	street, fact	tory, office			28f. Location (: City or To		Number or i	Rural Route Number,
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1			Kanan H. Hudhud,	22 Aggistrar's Sign		ohnso	on Dr	ive,	Fre	derick,	Mary	Land	
	St	ate	31. Date filed (Month, Day, Year)	106 32. registrars Sign	atura 6	march	2						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) **Physician** October 27, 2006 Maria L. Morales /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3518 Lowlen Ct. Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1/1/1937 Birthplace (State or Foreign Cuba 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 262-58-6055 1 □ M 2 □ F 69 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2□No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3518 Lowlen Ct. 21042 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 Married Cuban Specif Hispanic 1**X** Yes 2□ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hair Stylist/Owner Cosmetology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erundino Lorenzo Rosario Zamora ပ 19a. Informant's Name/Relationship (Type. Print)
Jorge Morales/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3518 Lowlen Ct. Ellicott City, MD 21042

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical **Examiner**

Baltimore, Maryland 21215-0036

Funeral

Director

The law requires that the death certificate be executed burial-trar attending physician for use as the buria as ed by the a detached f been signed be should be deta To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

Division or Vital Records, P.O. Box 68760,

	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	20b. Place of Dispos cemetery, crem. Metro Crem	atory or othe	er place)	Dat .0/28/		Location - City of tonsville	•
	21. Signature of Funeral Service Licens		1442 22.	Name and	Address of Facilit	^{ty} Harry	H. Witz		nily FH, Inc.
	23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the ne cause on each line.	e death. Do not ente	r the mode of		cardiac or			Approximate Interval Between Onset and Death
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Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2\$□ No 9 □ Unknown	23c. If yes, outcome pf 1 □Live birth 2 [4 □Pregnant at tin 9 □ Unknown	☐Fetal death 3☐I	Ectopic preg Other <i>(spec</i>				23d. Date of de Month	elivery Day Year
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Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc. (- At home, farm, stre (Specify)	et, factory, o	office	28	f. Location (Stree City or Town, S		Bural Route Number,
Medical Certification:		sician: To the best of r iner: On the basis of ex and manner stated	kamination and/or inv						
2	29b. Signature and title of certifier	1) [()	29c. L	icense number		29d.	Date signed (Mon	th, Day, Year)

State Registrar

31. Date filed (Month, Day, Year

DHMH 17 Rev 1/2001

e Patuxent Placy Columbia Md. 21044

		1 - For State Registrar	e of Maryland /	•	rtment of H tificate of L		, ,	iene eg. No. 🤈 🕦	00 20020
Physic		1. Decedent's Name (First, Middle, Last) Mattie R. Morris					2. Date of Deat Month October		3. Time of beath (06 6:55 a.M
/Med Exam		4a. Facility Name (If not institution, give street and 4710 Parkvale Rd.	d number)			Location of Death		4c. County of	f Death ward
Funera Directo		5. Social Security Number 213-44-8999 6. Sex 1 □ M 🔏	7. Age (In yrs. last)	birthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 6/4/1920	O ^{Year)}	9. Birthplace (State or Foreign Country) Maryland
Maryland t-f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County Md. Howard	10c. City, To		ation tt City	<u>,</u>			10d. Inside City Limits 1 ☐ Yes Ž No
h with the 23a or 28a st be noti	al Director	10e. Street and Number 4710 Parkvale Rd.			10f. Zip Code 210	43	1	0g. Citizen of Wh	-
Baltimore, IMaryland 21213-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any nice.	by Funeral	1 Never Married 2 Married 1 If Ye	Decedent Ever in U.S. ed Forces? Yes 2 Mos s, Give or Dates:	lf lf	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, White, etc. White
Maryland 21215-0036 of 2 should be filed within 72 hours af th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle 12yrs.		(Give k life. D	ent's Usual Occupa ind of work done of O NOT use retired an Office	luring most of work)	ing	16b. Kind of Busi	iness/Industry
and Z id be filed ental Hygid ked other ic event, ti	To Be Co	17. Father's Name (First, Middle, Last) Dewey R. Ensley				18. Mother's Nam	e (First, Middle, M	Maiden Surname,	
Mary Ind 2 shou alth and M 27 is mar		19a. Informant's Name/Relationship (Type. Print June Manning/daughter	1 2	19b. Mailing 4710	Address (Street a Parkvale	Rd. Elli	al Route Number	; City or Town, S ty, Md. 2	tate, Zip Code) 1043
Baltimore, bermit. Pages 1 at Department of Hea Important: If Item any Injury or othe		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	, ceme	etery, crem t Law	ition (Name of atory or other plac n Memoria	al 11/3/	′2006 N	Marriott	State sville, Md.
Ball permit Depart Import any In	au s	21. Signatur of Funeral Service Lionsee		45 41	12 Old C	olumbia E	ike Ell:	icott Ci	Family F.H.Inc ty,Md. 21043
Physician /Medical	-	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)		Interval Between Onset and Death					
cate be executed by striction and brystcian and cate the burial-transit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Le to (or as a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a conseq	Ry F	- IBROSIS				YEARS
Sath certifications as for use as	Physician/Medi	in the past 12 months?	s, outcome pf pregnancy Live birth 2 □ Fetal de Pregnant at time of death Unknown	ath 3□	Ectopic pregnancy Other <i>(specify)</i>			23d. Date Mont	
cords, P.O. w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing SEVERE HITRAL REG		_			23e. Did tot		oute to the cause of death? Probably 4 □Unknown
I Rec The law ate has b	Completed by	RUPHOSIS; HUPET	RLIPIDEMIA	4;	CORONAL	y Adrewy	24a. Was a autops perform	y pri ned? de	ere autopsy findings available for to completion of cause of eath?
n OF ng Phys fter this neraf di	Certification: To Be	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		b. Time of Injury		4 ☐ Nursing Ho	ome 5 Reside 28d. Describe ho	ence 6 □Other ow injury occurred	
DIVISIO Hospital or Attendil 24 hours after death. Funeral Director: A etely filled in by the fu		determined 200.	building, etc. (Specify)			ne, date and place	City or Towr	n, State)	
Div To the Hospital or A within 24 hours after To the Funeral Dire completely filled in bi	Medical	(Check only 2 Medical Examiner: On and 29b. Signature and title of certifications of the control	the basis of examination manner stated.	and/or inv	29c. License	number	2	9d. Date signed	(Month, Day, Year)
2		30. Name and address of person who completed	cause of death (Item 23)	ia) (Tvpe. F		3296		OCTOBET	30,2006
S	tate	JOSEPHF. GIBBONS.	MD 8186 32. Resistrar's Signature	LAR	LK BISOM	U ROAD	. ELKR	IDGE, A	ND 21075
Regis	trar	OCT 3 9 2006	MERLINE X	1 19	DENS				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 25, October 2006 1802 Agnes Lovina Naylor /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 M F 72 212-42-8490 July 5, 1934 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Glen Burnie Maryland Anne Arundel 10f Zip Code 10g, Citizen of What Country? 10e. Street and Number 510 B Street 21061 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Convalescent Elementary/Secondary (0-12) College (1-4or 5+) Center Nurses Aide Pages 1 and 2 should be filed vent of Health and Mental Hygid 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Kilmar John Anthony Jeclin or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lepartment of Health at In portant: If Item 27 is it at y Injury contact. 510 B Street, Glen Burnie, MD 21061 Samuel A. Naylor, Jr., husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville Vet Cem 10/30/2006 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home M01191 91 Willis Street, Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician PSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate dates. Enter tradeing of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: detached for use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Mapner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? after death.

I Director: After t 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours aft To the Funeral Discompletely filled in +Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 2001 30. Name and address of person what nne

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

06-08259

Please Type or Print in Black Indelible Ink

Doris Phillips State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 1, 2006 0651 hrs **Medical Examiner** Ramona Phillips Doris 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Dorchester **Canmbridge** 98 High Street Long Wharf Cambridge 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Min Director 1 M 2 F 215-26-7408 June 15,1930 Maryland 76 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State Yes 2 X No dother than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Dorchester MD Church Creek Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1212 Riverside Road 21622 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2. Was Decedent Ever in U.S 14. Race - American Indian, Black Armed Forces? White, etc. Never Married 2 Married 2 X No Yes white If Yes, Give Year 1 Yes 2 X No specify. 3 X Widowed Divorced Specify should be filed within 72 hours after and Mental Hygiene 7 is marked other than "natural", þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be or other traumatic event, Gorman Simmons Ruth Tyler 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh
Department of Health anc
Important: If item 27 is Leroy Bell 2828 Hoopers Island Rd., Church Creek, MD 21622 p.r. 20a Method of Disposition 20b. Place of Disposition (Name of cemetery. 20c Location - City or Town State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/3/06 Hurlock, MD Donation 5 Maryland Veterans Cem. Other Specify Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interva **Physician** Between Onset and /Medical Death Cardians aly with biventricular dilatation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit sician/Medical fing physician a X UNPENDED AMENDED #4b,23a,PII,27,perME, g862, 12/7/06 TT of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 V Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Yes 2 No 3 Probably 4 V Unknown Aortic valve calcification; hemochromatosis Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of this certificate has death? performed? ✓ Yes 2 1 Yes 25 Was case referred to medical 26 Place of Death (Check only one) Hospital or Attending Physician: Be Other₄ examiner? DOA Nursing Home 5 Residence 6 V Other Scene ER/Outpatient 3 Inpatient 2 1 🗸 Yes ပ္ No 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Division Yes 2 No To the Funeral Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide Could not be or Town, State) determined 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 1, 2006 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner State 6 2006 Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4a per doc 9861 11-14-06 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Day 27 **Physician** 2006 8:50 p M Szabo Puzzini /Medical 4a. Facility Name (If not institution, give street and number)
Gilchrist Center for Hospice Care 4c. County of Death 4b. City, Town, or Location of Death Examine Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 K□ F June 6, Yrs. 210-10-5952 Pennslvania 90 1916 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Howard Laure1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7909 Belgaro Road 20723 United States America Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be marked Steven Szabo Katalin Grunweber ٩ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathaleen Bond / Daughter 1428 North Halifax Avenue Daytona Beach 32118 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition important; If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory 11/1/2006 Catonsville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel, MD 20707 Van 23a. Part1. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): Examiner the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 250 No
9 Unknown 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy jo Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a Records, P.O. 9□Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform (es 2 certificate Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) HOSPICE 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 124 hours after death.

The Funeral Director: A pletely filled in by the funeral of the funeral death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (1601 N. Charles Street/Baltons 21204

State Registrar 31. Date filed (Month, Day, Year)

NOV 1 4 2006

State of Maryland / Department of Health and Mental Hygiena Reg. No. Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:00P M 21, 2006 Paul Austin Routzahn Oct. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Northampton Manor Nursing Home Frederick Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** .1**∑**M 2□ F 220-26-0056 91 1914 ΜĎ Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r then "natural", or itema 23a or 28a-f ehov tre Wedicul Examinar must be notified at 1 ☐ Yes 2X No Frederick Middletown **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8108 Myersville Rd. 21769 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed by 3€Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) I Hygiene. permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other tt any injury or other traumatic event, IIIA ONCE. construction carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Calvin W. Routzahn Anna Haupt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Spade (Daughter) 12802 Wolfsville Rd., Smithsburg, MD21783 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Osposition ☐Cremation 3 ☐Removal from State Lutheran cemetery 10/24/06 Middletown, MD 4 Donation 5 Other (Specify) 21. Signature of Fundial Source Licens e Donald Add B. Thompson Funeral Home E. Main St., Middletown, MD 21769 Parth. Enter the disease, or complications at sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician GEARS /Medical Due to (or as a consequence of) Examiner sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2[] No 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No P 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 PNatural 5 Pending investigation 1 ☐Yes 2 ☐No death. 2 Accident within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be determined 3 🗌 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 026499 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) MI ATO MI 27 the ROUMED LITTLE 4 CALOWELL BY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 4 2006 Jasak. Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year WILLIE SMITH JR. OCTOBER 18, 2006 8:55 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 1**X**M 2□F Months Days 189-26-8649 71 3 1935 May Clairton PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 19√1Yes 2 □ No Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1807 Belle Haven Drive 20785 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: **KOREAN** 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lawyer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Smith Sr. Mildred Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Smith /Daughter 9759 Goodluck Rd #5 Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 10-28-2006 Rosehill Cemetery Linden, New Jersey 22. Name and Address of FacilityPope Funeral Home ture of Funeral Service Licensee alon 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or comples shock, or heart failure. List only or Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

The law requires that the death certificate be executed

P.O. Box 68760,

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permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once.

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the Maryland

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

ca	ations that caused the death.
ι.	CHRONIC OBST
	Due to (or as a consequer
١.	HYPERTENSION
	Due to (or as a consequen

RUCTIVE PULMONARY DISEASE nce of)

ice of)

TOBACCO USE

Due to (or as a consequence of):

JE E	EMAL	E.
	LIVIAL	
22h	Was	doo

edent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4☐Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

ALCOHOLISM

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an 1 Yes No No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2▼ No

Year

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

27. Manner of Death 2 Accident

5 Pending investigation 6 ☐ Could not be determined 3 ☐ Suicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28h Time of (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 🗆 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certific

29c. License number # D58171

29d. Date signed (Month, Day, Year) OCTOBER 20, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAVJIT K. GORAYA, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 31. Date filed (Month, Day, Year)

State Registrar

UCT 3 0 2006

32. Registrar's Signature

			1 Argand #1 Per Phy Go	62 12/01/06 JF	1	Certifica	ite of L	Death			Reg. No	2006	36042
- 1	#		1. Decedent's Name (First, Middle, L	ast)					2	. Date of De Month	ath Da	y Year	3. Time of Death
-	Physici /Medi		Rosali Catherine Rosal i	e Smith					C	ctobe		9 200	
	Examir		4a. Facility Name (If not institution, g			4b. Cit	y, Town, or	Location of	Death		40	. County of De	ath
			Union Hospital				lkton					Cecil	
2	* Funeral		Social Security Number 6.	Sex 7. Age 1 ☐ M 2 🛣 F	e (In yrs. last bir	Month	er 1 Year s Days	If Under 2	Min.	. Date of Bir (Month, Da	rth a <i>y, Year)</i>	9. B	irthplace (State or Fore. Country)
7	Director		219-28-1888	70 W 2,A	74	Yrs.			J	uly 9	, 19	32 Mc	ryland
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	n or Location							10d. Inside City Limi
, 5	sho	ក			Mane	/ T 4							1 (XYes 2 □ h
٧)	28a-i	ect	MD Cecil 10e. Street and Number		NOTE	h East	Tip Code				10g. Ci	tizen of What (Country?
O	with a or	ā	150 Walton Lane				21901				11	CA	
• =	death with the Maryland ms 23a or 28a-f show rmits the notified at	era	11. Marital Status	12. Was Decedent E	Ever in U.S.	13. Was Dec		ispanic Orig	in? (Speci	fy Yes or No		SA 14. Race - Arr	
d "	<u> </u>	Funeral Director	1 Never Married 2 Married	Armed Forces?	ło				Puerto Ri	can, etc.)		Black, Wh	
Š Š	hours after turel', or its	b	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 L Yes	2 X No	Specify:				Specify: W	rite
Rosa	72 ho	Completed by	15. Decedent's (Specify only highest g	Education	16a.	Decedent's Us	sual Occupa	ation	of working		16b. K	ind of Busines	s/Industry
$\propto \epsilon$	within 72 ene. then "na	n p	Elementary/Secondary (0-12)	College (1-4or 5		(Give kind of v life. DO NOT		1)					
	filed wi Hygien other th	Con	9		1	Bank Cl	erk					anking	
9 5	ta la	Be	17. Father's Name (First, Middle, Las	st)			ĺ			First, Middle		i Sumame)	
7 5	y carry	P	Nathaniel Smoot							e wol	0		7.0.11
L 3	ic, Malylalla s 1 and 2 should be file f Health and Mental Hy Item 27 is marked oth other traumatic event		19a. Informant's Name/Relationship		196	. Mailing Addre							
\sim 1	C = '' L		Clara E. Holtzne	r/sister	20h Piace of	908 VV		a Ave.	., Ba	ltimo		MD 212 ocation - City of	
ather	Dalfilliole; Dermit. Pages 1 a Department of Her mportant: If Item nny Injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	cemeter	ry, crematory of	r other plac	1110	0-23-	2006		,	•
ナ	t. Pa tmen tant:		4 Donation 5 Other (Spec		K.T. F	oard Fo	unera	L Home	2, P.	Α.	Ris	ing Sun	, Maryland
0 6	Dalfillion permit. Pages Depertment of Important: If it any Injury or o		21. Signature of Funeral Service Lic	ensee O	1-	ZZ. Name	and Addres	ss of Facility	R.T.	Foard	d Fu	neral H	lome, P.A.
			23a. Part 1 Enter the disease, or co	molications that caused	the death Do	not enter the m	S. Qu	een Sa	ardiac or r	using aspiratory a	Sun	, MD 2	Approximate
2			shock, or heart failure. List on	y one cause on each lin	10.	4	3 a a a a a a a a a a a a a a a a a a a	9, 000, 000	D	3			Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Acute	Lype	Krc P	espie	refuz	te	lune			2 hours
	Examiner			Due to (or as	a consequence	of):	¥:						
79W		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence	of):							
	uted Insit	n in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
_	exection and in all tra	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence	of):							
03203	tificate be executed g physician and as the burial-transit			d									
0	tificat g phy as th	Medical											
3	eath certif		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth	of pregnancy 2 Petal death	3 □Ectopic	pregnancy					23d. Date of d	
0	In Attending Physician: The law requires that the death certificate be executed death. I or Attending Physician: The law requires that the death certificate be executed death. Director: After this certificate has been signed by the ettending physician and in by the funeral director, page 2 should be detached for use as the burial-train.	Completed by Physician/	in the past 12 honths?	4☐Pregnant at 9☐Unknown		5 Other (·····				Month	Day Year
	at the lby the	Ph.	9 □ Unknown							00 011			to the course of death 3
(es the igned	۵	Part II. Other significant conditions			n the underlying	g cause give	en in Part I.					lo the cause of death? Probably 4
1	equii een s	ted	IT CUTE 1 CTT	sitted JTY	roke.					-	Yes 2	1	
	law law law bas b	ple	Emplyseury			•				24a. Was auto	psy	24b. Were a	autopsy findings availat completion of cause o
	The zate page	S	Profeir Ca	(one M	9(40 m	trey				1 Yes	2 ZINO	death?	s 2 No
	iclan: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Handah (-			0#		of Death (Check only	one)		
5	Physic this c	ျ	1 Yes 2 No		nt 2 ER/Ou			4 🗀 1401:				6 ☐Other (Sp	ecify)
,	fing I. After Tune	lo	27. Manner of Déath 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Y Year)	Time of njury M	28c. Injun Worl	yai k? Yes 2 □ N		d. Describe	now inju	ry occurred	
	or Attending after death. Director: After in by the funer	cat	2 Accident investigat 3 Suicide 6 Could not	be gas Blace of Inju	int - At home fa					f Location (Street at	nd Number or i	Rural Route Number,
	or A after Direction by	Certification:	4 Homicide determine	building, etc	. (Specify)	iiii, 311601, 1401	ory, ornog			City or To	wn, State	9)	
	spital ours nerel filled		29a. Certifier 1 Certifying	Physician: To the best of	of my knowledge	e, death occurre	ed at the tin	ne. date and	place, and	d due to the	cause(s) and manner	as stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: Atter this certificate his completely filled in by the funeral director, page	Medicai		aminer: On the basis of and manner sta	examination an								
	To the within Fo the compl	Me	29b. Signature and title of certifier	1			29c. License						nth, Day, Year)
	->		> py as	- my			000	551	90	1	Octo	ber 20	2006
	7		30. Name and address of person wh	o completed cause of de	eath (Item 23a)	(Type, Print)						C1	11:10
	4		Alfred AF	on on	V4104	Hos!	reful	106	Roc	stre	ect	C/Kfo	2006 m
		ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	alle							
	Regist	rar	OCT 2 6 2008	WIND.	10 19								

DHMH 17 Rev 1/2001

OCT 2 6 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death PETER SIMPSON Month 26 5:00PN 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center BALTIMORE Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Months Hours 089-40-9609 67 09-22-1939 England Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Somerset Princess Anne 10e. Street and Number 10g. Citizen of What Country? 27225 Oriole Road 21853 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify 3 ☐ Widowed 4 ☐ Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Manager Robotics Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Simpson Doris Victoria Simpson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Brown Simpson/Wife 27225 Oriole Road, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 10/28/06 Salisbury, Maryland Signature of Funeral Service Licenses 22 Name and Address of Facility Hinman Funeral Home ,M00295 11673 Somerset Ave., Princess Anne, MD 21853 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non Small cell lung cuncer MOINTH Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 5 ☐ Other (specify) Month Year 4□Pregnant at time of death 9 Unknown ions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DISEASE PULMONARY 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any finury or other thaumatic event, the Medicel Examine

Baltimore, Maryland 21215-0036

be notified at

Director

Funeral

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Completed

Be

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Il or Attending Physician: The law requires that the death certificate be executed after death.

1 Director: After this certificate has been signed by the attending physician and in by the functed infector, page 2 should be deteched for use as the burina-transit

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed Be ٩ Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
Part II. Other significant condit

26. Place of Death (Check only one)

28d. Describe how injury occurred

25.	Was case	referred to medical	1
	examiner's	2 NO	Hos
27.	Manner of	Death	

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Impatient

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

1 Natural

2 Accident 3 Suicide

4 ☐ Homicide

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year) 10/26/2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CISSELL 22 South Greene St., Baltimore, MD 21201

KERRI 31. Date filed (Month, Day, Year)

32. Registrar's Signature

issell, MD



ORIGINAL

DHMH 17 Rev 1/2001

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Medical

State Registrar

or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital To the

23s Certifier 🔭 Gertifying Physician: To the best of my knowledge, death cooursed at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 251735 26706 WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK W. DELBOY, M.D., 6602 CHURCH HILL RD., STE 200, CHESTERTOWN, MD 21620

State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1- State of M		artment of Health and rtificate of Death	d Mental Hygier	7000 00040
3.			Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
180	Physici		Harry H. Swomley.	Ir.		October	29, 2006 11:50 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number		4b. City, Town, or Location of De		c. County of Death
			St. Catherine's Nursin	g Home	Emmitsburg		Frederick
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year If Under 24 H Months Days Hours M		9. Birthplace (State or Foreign Country)
(93)	Director		214-36-0002 1XM 2□F	92 Yrs.		Oct. 17, 1	
	pu k		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	eho	5	Maryland Frederick	Emmitsl			1 ☐ Yes 2 Д ☐ No
	28a-1	Director	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?
	with o				21727		nited States
	ns 23	era	15201 Sixes Road 11. Marital Status 12. Was Deceden	Ever in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		14. Race - American Indian,
(0	riter	Funeral	Amed Forces 1 □ Never Married 2 ☑ Married 1 □ Yes ☑ If Yes, Give	? No		erto Rican, etc.)	Black, White, etc.
5-0036	within 72 hours after deeth with the Maryland ene. than "natural", or Items 23e or 28e-f ehow ha Madical Exami at must be indified at	þ	3 Widowed 4 Divorced Year or Dates:		1 ☐ Yes 2 💢 No Specify:		Specify: White
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of v	working 16b.	Kind of Business/Industry
2121	thin .	npie	Elementary/Secondary (0-12) College (1-4or	life.	DO NOT use retired)		
21	ygier ygier th		7	Fai	ming	lame (First, Middle, Maid	Dairy
ī	be fill d ott	Be	17. Father's Name (First, Middle, Last)			,	•
Maryland	J Mer nark	2	Harry Swomley 19a. Informant's Name/Relationship (Type, Print)	10h Maili	ng Address (Street and Number or	lie Remsberg	
N	d2 st th and 7 ts r traur		Helen Swomley / Wife		Sixes Rd., Emm		
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be notified at ADE.		20a. Method of Disposition	20b. Place of Dispo	sition (Name of		Location - City or Town, State
Baltimore	ages int of t: ff it		14 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify))	matory or other place)	/2/2006 Fr	ederick, Maryland
臣	artme orten injur		21. Signature of Funeral Service Licensee		et Cemetery 11 2. Name and Address of Facility	Stauffer Fu	
Ba	Depermine Important in Importan		Yourney Stautter		621 Opossumtown		
			23a. Part1. Enter the disease, or complications that cause	d the death. Do not en			Approximate Interval Between
	Physician		shock, or heart ailure. List only on cause on each immediate Cause (Final	8 x 0 1	th	e e to	Onset and Death
	/Medical		disease or condition resulting in death) aa.	s a conseque ce of)	non pem	in un	200
	Examiner		Uthe	ioscheid	ic Cardiova	scula A	isease 20 yrs
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequence of):			9
	acute ind trans	Examiner	triat irritiated events C.				
30,	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit		Due to (or a	s a consequence of):			
8760	physic the b	dicai	d	-			
9	ding page as	Me	IF FEMALE: 23c. If yes, outcom	e of pregnancy			and Date of delicery
Вох	atten for us	ian	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
-	that the death certific ed by the attending p detached for use as	ysic	1 Yes 2 No 9 Unknown				
P.0	that led by deta	든	Part II. Other significant conditions contributing to death,	but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	use contribute to the cause of death?
ds.	tw requires that s been signed b t should be det	D D	Insulin Depend	ent Di	slietes	1 ☐ Yes	2No 3 Probably 4 Unknown
00	w req	ete	0			24a. Was an	24b. Were autopsy findings available
Re	icien: The lav certificete hes ector, page 2	Completed by Physician/Me				- autopsy performed? 1 Yes 2 €	prior to completion of cause of death? lo 1 □ Yes 2 ☒ No
ta	en: T	0	25. Was case referred to medical		26. Place of E	1 ☐ Yes 2 ☑ N	10 105 200,40
\geq	Physicien: r this certifice ral director, i	To B	examiner? 1 Yes 2 No Hospital: 1 Inpat	ient 2 ER/Outpatier	nt 3 DOA Other: 4 Nursing	g Home 5 Residence	6 ☐Other (Specify)
0	ng Ph ter th neral	Ë	27. Manner of Death 28a. Date of In (Month, D	ury 28b. Time o		28d. Describe how in	
Ö	endir sath. or: Af he fu	atic	2 Accident investigation		M 1 Yes 2 No		
Division of Vital Records,	ter de irect	Certification:	3 Suicide 6 Could not be determined 28e. Place of tre building, 6	ijury - At home, farm, str tc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ite)
0	To the Hospitel or Attending Physicien: The lawithin 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	Ce			ears of the control o		Photographic Control of the Control
	Hosp 24 hou Fune tely fi	Medical	(Check only one) 2 Medical Examiner: On the basis one)	of examination and/or in			
	thin 2 thin 2 the mple	Mec	29b. Signature and title of certifier	la a	29c. License number	29d. 0	Pate signed (Month, Day, Year)
	F ≱ F 8		() () () () () ()	OHALIM	N D18705		10/30/06
	1.		30. Name and address of person who completed cause of	death (Item 23a) (Type		,	1-1001-0
	V		Alan Carroll, MD 310 S. Se			1727	
- 12	Sta	ate		1 0:	Carle		
	Registi		OC 3 + 7800	we so so			

		-	For State	State of Ivia	aryland / Depa <i>Ce</i>	rtificate of		-	Reg. No.	U6	36046
	-		Registrar 1. Decedent's Name (First, Middle, Lasi	"				2. Date of De			3. Time of Death
675	. Physici	an						Month Octobe	r 27	2006	8:44 A M
1	/Medic		Helen E. 4a. Facility Name (If not institution, give	Snyder		4b. City. Town.	or Location of Deat		4c. Coun		
	Examin	er	Beverly Health (rick		ederick			•	rick
- 2	F		5. Social Security Number 6. Se		e (In yrs. last birthday)	If Under 1 Yea	If Under 24 Hrs	8. Date of Bir	th	9. Bir	thplace (State or Foreig
	Funeral Director			☐M 2⊠F	79 Yrs.	Months Day	s Hours Min.	June 26	$\frac{1}{2}$, $\frac{1}{1}$		ountry)
	ס		Usual Residence of Decedent								
	how		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	e Ma	Funeral Director	Maryland Frederi	ck	N	ew Marke	et				1 ☐ Yes 2 No
	or 28	Sire	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Co	ountry?
	15 wi	a	5731 Meyer Avenu	e			21774				d States
	dea -	mer	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Origin? (S uban, Mexican, Puer	specify Yes or No to Rican, etc.))- 14. R: BI	ace - Ame ack, Whi	erican Indian, te, etc.
2	or it	T.	t Never Married 2 Married	1 ☐ Yes 2 ☒ N If Yes, Give	10	1 ☐ Yes 2 🛣 N	o Specify:		Spec	ify:	White
Ś	72 hours after death with the Maryland natural, or items 23s or 28s-1 show dical Examinan must be maillist at	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	100 8000	d#-111 O			16b, Kind of	D	And the
213-0030	nat	lete	15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occ kind of work don DO NOT use reti	ne during most of wo	rking	Tob, Kind of	Dusiness	vindustry
717	within lene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Homemal				wn H	Iome
A	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heeth and Mental Hydiene. Department: If them 27 is marked other then "natural; or iteme 23a or 28e-1 ehow eny injury or other traumatic event, its Madical Examirat must be notified at once.		17. Father's Name (First, Middle, Last)					me (First, Middle			
0	d be ental ked o	To Be	Xeno Stansbury				Helei	n Kratz			
Mai yiaiin	mar mar	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Maili	ng Address (Stree	et and Number or Ri	ural Route Numb	er, City or Tow	n, State,	Zip Code)
2	and 2 :		Norman C. Snyder	/ Son	315	Willows	len Avenue	e Mt. A	irv. Ma	rv1a	nd 21771
ນົ	Hee tem		20a. Method of Disposition		20b, Place of Dispo			Date	20c. Location		
2	Peges nent of int; if it iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify		Frederick		OCL	ober 2006	Freder	ick.	Maryland
	ortan	1	21. Signature of Funeral Service Licens			2. Name and Add					es, P.A.
ă	permit. Depertr imports eny inju		129.1	*	8	E. Ridg					yland 21771
	4		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death. Do not en						Approximate Interval Between
H	Physician		Immediate Cause (Final	CENE		Ascum	Acci	DEWT.			Onset and Death
il.	/Medical		disease or condition resulting in death)	a	a consequence of):	· >Compc		V ()			
	Examiner			myo.	CARDIAL	Inform	CTION.				
	77	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
	and and i-transit	xamlner	that initiated events	ceno	rany !	mteny	DISE	12-50			
Ś	en ar rial-t	Ψ	resulting in death) Last	Due to (or as	a consequence of):						
00/00	death certificate be ex e attending physicien a of for use as the burial	Physiclan/Medical		d							
0	ng ph as t	Med	IF FEMALE:								
POX	ath ce ttendi	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnar				ate of de Ionth	livery Day Year
5	e de the a	Sic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death 5L	Other (specify)					•
į.	law requires that the de as been signed by the a 2 should be detached t	Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the u	nderhing cause i	oven in Part I	23e Did t	obacco use co	ntribute t	o the cause of death?
ń	ires tha signed I	by	Part II. Other signmeant conditions of	This dailing to document	st not rossemig in the s	indonying daddo g	givori iii v div i.		Yes 2□No		robably 4 Unknown
5	w require been si should I	eted									
Records,	has b	Completed						24a. Was		. Were a prior to death?	utopsy findings available completion of cause of
_	pa ale	S						1 ☐ Yes		1 Yes	s 2⊠ No
Vilai	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			han.	ath (Check only o			
5	S O D	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 🔲 Inpatie		IL 3 DOA		lome 5 ☐ Resi 28d. Describe			ecify)
		5	1 ⊠Natural 5 ☐ Pending	28a. Date of Injud (Month, Da)	Year) Injury	W	ork? ☐ Yes 2 ☐ No	280. 0430100	now injury occi	11160	
2	ten leat tor: the	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ury - At home, farm, st			28f Location /	Street and Nun	ther or R	ural Route Number,
5	i Dife	Certification:	4 Homicide determined	building, etc	(Specify)	out, recory, onto	~	City or To			
	ospital or A hours after uneral Directly filled in by		29a. Certifier 1X Certifying Phy	sician: To the best	of my knowledge, deat	h occurred at the	time, date and place	a, and due to the	cause(s) and r	nanner a	s stated.
	To the Hospital within 24 hours a forthe Funeral completely filled	edical			examination and/or in						
	4 5 4 6	Me	29b. Signature and title of certifier				nse number		∠9d. Date sign	ed (Mont	th, Day, Year)
	0 = 0 5						04795				

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 814 Toll House Avenue Frederick, Maryland 21701 Sibte A. Kazmi, M.D.

nn

31. Date filed (Month, Day, Year)

OCT 3 1 2006



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [5] Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month IPM William Aloysius Scott ctober 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death al Under 24 Hrs. 8. Date of Birth Hours Sep certific ay. 138, 19 15 New 9. Birthplace (State or Foreign Days 1**X**]M 2□F 107-14-3403 91 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐XNo MD Charles La Plata 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 704 Pine Street 20646 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 3 Married 1 ☐ Yes 2 1 No White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personnel Director Federal Govt. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Eckhardt Scott Mary Fitzpatrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Pine St. La Plata,MD 20646 Anna Scott/Wife 20b. Place of Disposition (Name of 20a. Mathod of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Ceme.10/30/06 La Plata,Maryland 21. Signature of Funeral Service License 100945 AREHART-ECHOLS FUNERAL HOME, P.A. 211 St.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Mary's Ave. La Plata, MD 20646

Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE HRONIC Lyona Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician /Medical Examiner

and

Physician

/Medical

Examiner

Funeral

Director

28e-f ehov

or Iteme 23a or

"neturel"

permit. Pages 1 and 2 should be filed within 72 Department of Heelth and Mental Hygiene. Important: If Item 27 ie marked other then "ne eny injury or other treumatic event, the Macing Once.

injury or other treumatic event, the Madical Examiner must be notified at

Funeral Direct

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Be Completed

within 24 hours after death.

To the Funerel Director: After thi completely filled in by the funeral

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

1	1	F	4	2
dical Examiner	y Physician/Medical	ition; To Be Completed by Pt	To Be	ertification;

cal Ex	resulting in death) Last	Due to (or as a consequence of): d								
hysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year							
a	Part II. Other significent conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?							
D D	ATHERO-SCLE	EROTIC HEART DISEASE	1 Yes 2 No 3 Probably 4 Unknow							
Completed by	HYPERTEN	SION	24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ No							
ø	25. Was case referred to medical	26. Place of Death (Check only one)								
10 B	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Specify)							
atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	on (Month, Day Year) Injury Work? M 1 Yes 2 No	8d. Describe how injury occurred							
Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		8f. Location (Street and Number or Rural Route Number, City or Town, State)							
edical	29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex	Physician: To the best of my knowledge, death occurred at the time, date and place, a sminer: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)							
ž	29h Signature and title of certifier	29c. License number	29d Date signed (Month, Day, Year)							

260104

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Qay, Year)

person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar		Stat	e of Mar	yland /		artmen tificati				lental Hy	gien Reg. N	7 11 11 6	5	36048
*	Physici	an	1. Decedent's Name (/	^	1	. /							2. Date of De Month		ay Ye	ar	3. Time of Death
	/Medic	cal	4a. Facility Name (If no	Brogd		whe	2		4h Cihi	Tour	Location of	of Dogth	Octobe		5 200 c. County of D	6	11:20a M
	Examir	ier	Carroll F						40. City,						•		
	Funeral		5. Social Security Num	ber 6	. Sex	7. Age ('In yrs. last		If Under Months	1 Year Days	mins If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di	th av. Year	Carr		ace (State or Foreign
¥.	Director		213-46-456 Usual Residence of De		1 □ M 2 🗓	KF	98	Yrs.					March	15	1908		Brazil
	yland pow			0b. County		1	Oc. City, To	own or Lo	cation			-				10	d. Inside City Limits
	a-f er	ctor	MD	Carr	roll			West	minst	ær							1 ☐ Yes 2 XNo
	vith th	Director	10e. Street and Number						10f. Zip					10g. C	itizen of What	t Count	ry?
	na 23	Funeral	3200 Litt	Lestow		Decedent Eve	er in U.S.	13. \	Vas Deced		.158	ain? (Spe	acify Yes or No)-	USA 14. Race - A	America	ın Indian
SHRIVER 215-0036	filed within 72 hours after death with the Maryland Hygiene thar then "neturel", or liema 23a or 28a-f ehow ont, tra Medical Examirar must be notified at	þ	1 ☐ Never Married 3 ☑ Widowed 4 [Arme	ed Forces? Yes 2 X No s, Give or Dates:			f Yes, spec		Specify:		ecify Yes or No Rican, etc.)		Black, Vi	Vhite, e	
5 E	72 hours "neturel",	etec		only highest o		eted)	16	Sa. Deced	lent's Usua kind of woi DO NDT us	l Occupa k done di	tion uring mos	t of worki	ng	16b. I	Kind of Busine	ess/Ind	ustry
N S	within ene. then	Completed	Elementary/Seconda	ary (0-12)	Colle	ege (1-4or 5+)		IITO. L		in retired) Make					Own Ho	nma.	
DE id 2	0 - 0 5	Be Co	17. Father's Name (Fir	st, Middle, La	st)				HOLE			or's Name	(First, Middle	, Maide		AIIC	
BROGDEN ryland 21		To B	Henry Ca	rter E	rogder	1					He	elen	Igleha	rt			
HELEN B	d 2 strauture d		James M. S			son		330	0 Lit	tles	town		al Route Numb West				21158
HELEN BROGDEN SHRIVE Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Heali Important: if Item 2 eny injury or other 2006.		20a. Method of Dispos 1 Surial 2 0 4 Donation 5	Cremation 3		from State	20b. Place ceme Tri n		sition (Nan natory or o Episc		1		72006		ocation - City Green		
Bait	permit. Depart Import eny inj		21. Signature of Funer	. 11	eesnes								e and C d West				21157
*			23a. Part. Enter the shock, or heart fa	ailure. List on	mplications t ly one cause	on each line.			0	A				rrest,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Fir disease or condition resulting in death)	nal	a		rov		lar	Ac	cid	ert				1.	cys
	Examiner		- ·		Du	e to (or as a o	consequenc	e of):									/ /
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8760,	ate be executed sysician and he burial-transit	Ical Ex	rosulting in deatify Eas	` I	Du	e to (or as a c	consequenc	e of):									
687	ficate physis the				d.											1	
P.O. Box	The law requires that the death certificate te has been signed by the attending phys age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pr in the past 12 me 1 ☐ Yes 2 ☑ N 9 ☐ Unknown	nths?	1 □ L 4 □ F	s, outcome of live birth 2 [Pregnant at tirn Unknown	Fetal dea		Ectopic pro Other (sp.						23d. Date of Month		y Day Year
	w requires that s been signed b should be deta	by	Part II. Other significa	nt conditions	contributing	to death but r	not resulting	g in the ur	nderlying ca	ause givei	n in Part I.						cause of death?
Division of Vital Records,	The law req ate has beer page 2 shou	Completed	24a. Was an autopsy prior to death?									to com	sy findings available pletion of cause of				
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred examiner?	to medical								of Death	Check only				
ð	di S	2	1 Yes 2 No		Hospital:	1 Inpatient	2 ERV	Outpatien			4 140		ne 5 ☐ Resi			Specify)	
o U	fren	tlon		5 Pending investigat		Date of Injury Month, Day Y	'ear) 280	Injury	M 2	Bc. Injury Work'			28d. Describe	now inju	iry occurred		
Divisi	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ertification:	2 Accident 3 Suicide 4 Homicide	6 Could not determine	be 28e. F	Place of Injury ouilding, etc. (- At home, (Specify)	farm, stre				28f. Location (Street and Number or Rural Route Number City or Town, State)				Route Number,	
	n 24 hospit. n 24 hours ne Funera	edical C	29a. Certifier 1[(Check only 2[one)	Certifying I	aminer: On i	o the best of r the basis of ex manner states	camination a	lge, death and/or inv	occurred a estigation,	at the time in my opi	e, date ani inion, dea	d place, a	and due to the ed at the time,	cause(s date an	s) and manner od place, and	r as sta due to	ited. the cause(s)
	To the To the Comp	Ň	29b. Signature and title	e of certifier					29c	. License		·			ate signed (M		ay, Year)
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	15		30. Name and address	4		cause of deat	Λ			7 ,	4 m L		o de	2	1.000		
-	Sta	te	31. Date filed (Month,		295	32. Registrar's	Signature		30		051 es	-254	e all		1115/		
	Registr	200	0	CT 27	2006	32. Registrar's	s A	k /	La. N								
DH	MH 17 Rev 1/2	001						19	-								

ORIGINAL

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			For	State of M	aryland	d / Depa	artment of H	lealth and N	∕lental Hy	/giene	0.6	36.04.9
		•	1 = State Registrar			Cei	rtificate of i	Death		Reg. No.		00,000
			1. Decedent's Name (First, Middle	, Last)					2. Date of D			3. Time of Death
	Physicia /Medic		LUCILL	E	TI	AC	KER		OCTO!	BER 27	200	6.45AM
	Examin		4a. Facility Name (If not institution	give street and number,)		4b. City, Town, or	Location of Death		4c. Cour	ity of Death	
1		-	HCR MANOR CAR	Ε			SII	VER SPRI	NG	MO	NTGON	1ERY
	Funeral		5. Social Security Number		ge (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	irth	9. Birth	nplace (State or Foreign Intry)
ı	Director		233 38 8938	1□M XXF	•	79 Yrs.	Months Days	Hours Min.	FEB. 0	2, 1927	WES	T VIRGINIA
	pu ,		Usual Residence of Decedent		100 Cibi	, Town or Lo	ention					10d. Inside City Limits
	rylai hov		10a. State 10b. County		TOC. City	, TOWITOF LC	cation				ĺ	
	the Marylan 28a-f show	Director	MD PRINCE	GEORGES	CAI	PITOL	HEIGHTS					XXYes 2 □ No
	or 28	Ē	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cou	intry?
	72 hours atter death with the Maryland natural; or Items 23a or 28a-1 show Iteal Examitrational to mailified at	ai D	732 LARCHMONT	AVENUE			207	43		UNITE	ED STA	ATES
	dea	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp	ecify Yes or N	0- 14. R	ace - Amer	ican Indian,
9	after or ite	교	1 Never Married 2 Marri			ì		Specify:	, , , , ,			,
8	al', c	by	3 ☐ Widowed ★☆Divorced	Year or Dates:			1 ☐ Yes 2/CXNo	<i>Specity:</i>		Spec	my: Wh	HITE
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hyglene. It Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event. It a Medical Examination at the multiple of the content	Completed	15. Decedent (Specify only highes			(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of worl	king	16b. Kind of	Business/l	ndustry
2121	filed within I Hygiene. other then "rent. It e Mas	dwo	Elementary/Secondary (0-12)	College (1-4or	5+)		T WRAPPER	,		GT A	ANT FO	OODS
	filed Hygi ther	O	17. Father's Name (First, Middle,	Last)			. ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	18. Mother's Nam	e (First, Middle			, , , , , , , , , , , , , , , , , , , ,
Maryland	Mental Mental arked o	8	CLARENCE PETER	C C				KATE PE	ጥ፱፻፫			
2	should be nd Menta marked maric ev	မ				ton Maille	ng Address (Street			has City as Tau	- Ctoto 7	in Codal
ā	2 sho and Is ma		19a. Informant's Name/Relationsh				,					·
	1 and Health em 27 other tr		BERTHA THACKER	/ SISTER-IN			LARCHMONT					1D 20746
Sre	of H fital		20a. Method of Disposition 1 Burial 2XXCremation	2 Domoval from State		ace of Dispo emetery, crei	sition (Name of natory or other place	ce)	Date	20c. Location	n - City or T	Town, State
Ĕ	Pag nent ant: J		'4 □ Donation 5 □ Other (S)			ropol	ITAN CREM	ATORY 10	/26/06	ALEX	ANDRI	A, VA
Baltimore	permit. Pages 1 a Department of Hee Important: If item any injury or othe		21. Signature of Funeral Service	icensee austll		22	Name and Address MARSHALI 4308 SUI	ss of Facility S FUNER TLAND RO	AL HOME AD SUI	OF MAR	RYLANI MD 20),INC.
	OT THE		23a. Part . Enter the disease, or show, or heart failure. List	complications that cause	d the death	. Do not ent	er the mode of dyin	ig, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a A C	UT	EI	NYOCA	RDIAL	IN	FARC	401	Onset and Death

/Medical Examiner

Examiner Physician/Medicai Be Completed

attending physician and for use as the burial-transil use as the After this certification, funeral director, within 24 hours after death To the Funeral Director:

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Certification: To

Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 2 Fetal death 4 Pregnant at time of death

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an 1 Yes ZXNo

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

4XXVnknown

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No
27. Manner of Death

1 Natural 5 Pending

investigation

28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Norsing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔁 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes 2 No 3 Probably

(Check only
(Ollowit olli)
one)
0110)

2 Accident

3 Suicide

4 - Homicide

2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated.

30. Name and address of person who completed care

GOSIN NAVIHE 31. Date filed (Month, Day, Year)
OCT 2 7 2006

29b. Signature and title of certifier

of death (Item 23a) (Type, Print)

State Registrar

State of Maryland / Department of Health and Mental Hygien® 36050 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear **Physician** 1:15p 10-20-2006 ROSA ELIZABETH THALLEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S LANHAM DOCTOR'S HOSPITAL 9. Birthplace (State or Foreign Country) West Virginia Il Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 ☐ M 2 ☐ F 02-05-1924 Director 578-22-1012 Usuat Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a State 10h Counts rel', or items 23a or 28a-f ehow Examiner nest by nutified at 1 HYes 2 □ No Director Washington D.C. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20013 USA 3001 Bladensburg Road, N.E. Funeral filed within 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2¾ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: **Black** Specify: Completed by 3₩Widowed 4 Divorced "naturel" th and Mental Hygiene.

7 ie marked other than "natur traumatic event, tre Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) D.C. Government 12th Housekeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked other eny lighty or other traumatic event 2008. Be Willie D. Waller James Lloyd Waller P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Waller-Mason/sister in law Ft. Wash., MD 20744 2304 Thornknoll Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lincoln Mem. Cemetery 10/26/2006 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Helgman MO1374 Mary Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIOPULMONARY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner **SEPTICEMIA** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (ur as a consequence of): Examine The law requires that the death certificate be executed METABOLIC DERRANGEMENT and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physicien for use as the buria COLON RESECTION Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) by the detached 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 4 DUnknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably DEMENTIA Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes certificate 36 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. D. te I Injury (Month, Day Year) 27. Manner of Deat 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D61552 October 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin Erfan 8118 Good Luck Road L 20706 Lanham, Maryland Kevin Erfan 31. Date filed (Month, OCT \$2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item# 20b,per f.h., 10/30/06, bg Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** 2006 TYLER 12:53 A.M. MILES October /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street end number) 4c. County of Death Examiner Somerset McCready Memorial Hospital Crisfield If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. October 9. Birthplace (State or Foreign Country) 24 Maryland 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1⊠M 2□ F 82 Yrs. 1924 218-16-6785 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Crisfield Somerset Maryland 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 5179 S. Pomfrett Road 21817 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Depertment of Heelith and Mental Hygiene. Important: If them 27 is marked other than "ne any Injury or other traumatic event. Somerset County Elementary/Secondary (0-12) College (1-4or 5+) School Bus Contractor Board of Education 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hettie Miles Howard W. Tyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosabelle Tyler (Wife) 5179 S. Pomfrett Road - Crisfield, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date Sunn ridge Memorial Park 10/10/06 1 € Burial 2 Cremation 3 Removal from State Crisfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 1 Surfer 1 Service License 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw Fr. 306 W. Main St.- Crisfield,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. 306 W. Main St. - Crisfield, MD 21817 Approximate Interval Between Onset and Death Physician disease Immediate Cause (Final disease or condition resulting in death) /Medical Examiner consequence of Completed by Physiclan/Medical Examiner ettending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 12 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Man of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? tours efter death.

neral Director; After the filled in by the funera 5 Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours e To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified completed cause of death (Item 23a) (Type, Print 30. Name and address of person who T. occimo? 604-

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Here It Spark

			1 - State of Mary		artment of Hea rtificate of De			ene g. No2 0 0 6	36052
	Physici	an	1. Decedent's Name (First, Middle, Last) Ellen Flora Thompson				Date of Death Month	Day Year	3. Time of Death 6:30 P M
)	/Medic Examin		4a. Facility Name (If not institution, give street and number) 119 Duval Lane		4b. City, Town, or Loc Edgew	cation of Death	ctoper	24, 2006 4c. County of Deat Anne	
	Funeral Director		045 00 4767 10H 30F	yrs. last birthday) 74 Yrs.		lours Min.	8. Date of Birth (Month, Day, August 7	Year) Co	hplace (State or Foreign untry) Shington, DC
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Lo	ocation				10d. Inside City Limits
	a-fah	ctor	Maryland Anne Arundel		Edge	water			1 ☐ Yes 2402(No
	h with th	ai Director	10e. Street and Number 119 Duval Lane		10f. Zip Code 21	037	10	og. Citizen of What Co U.S.A	•
980	ges 1 end 2 should be filed within 72 hours after death with the Maryland to fleatin and Mental Hygiene. If the 27 is marked other than "natural", or items 23a or 28a-f ahow or other traumatic avant, the Madical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Amed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 🕱 No Si	nic Origin? (Spec Mexican, Puerto F Specify:	ofy Yes or No- lican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
Maryland 21215-0036	within 72 ho ane. than "natur se Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	(Give	edent's Usual Occupation be kind of work done durin DO NOT use retired) Payroll	n ng most of workin	g	State Gove	
land 2	ild be filed viental Hygierkad other lic avant, II	To Be Co	17. Father's Name (First, Middle, Last) George F. Williams		18.	Mother's Name Pansy A	(First, Middle, M		
Mary	nd 2 shou alth and M 27 is mar ir fraumat	_	19a. Informant's Name/Relationship (Type, Print) Dennis Thompson/son		ing Address (Street and I Duval Lane		Route Number, Cer, Mar		· ·
Baltimore,	permit. Pages 1 end 2 Department of Health a Important: if item 27 it any injury or other tra		1 Burial 25 Cremation 3 Removal from State	•	matory or other place)	l s		0c. Location - City or	
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,	Physician /Medical Examiner	Iner	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry)	nsequence of):	iter the mode of dying, su	71	respiratory arre	y Juleas	Approximate Interval Between Onset and Death
8760,	cate be executed bhysicien and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a cord d.	rsequence of):					
.O. Box 68	The law requires that the death certific. te has been signed by the attending pl page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	ivery Day Year
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		Completed	Mellous type 2, Hypertension, B	Rena	Disea Cancer	باعر	24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
Vita	hysician: The is nis certificate ha I director, page 2	Be	25. Was case record to medical examiner?		26	. Place of Death	(Check only ont	5)	
Division of	ding PI n. After tr funera	tion: To	1 Yes 2 No	2 ER/Outpatier 28b. Time of Injury	of 28c. Injury at Work?			nce 6 Other (Spec w injury occurred	cify)
Divisi	el or Attand s after death il Diractor: / id in by the f	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury building, etc. (S	At home, farm, st	treet, factory, office	2	8f. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,
	To the Hospitel or Attenwithin 24 hours after deall To the Funeral Director: completely filled in by the	edicai	29a Certifier (Check only one) 1 Certifying Physician: T; the best of my one) 2 Medical Examiner: On the basis of examiner stated.	r knowladge, deal mination and/or in	th occurred at the time of	date and place at on, death occurre	nd duc to the ca d at the time, da	use(s) and tranner us te and place, and due	to the cause(s)
	To the within 2 To the complet	W	29b. Signature and title of centifier	Mis	29c. License nu	648	8	od. Date signed (Month	n, Day, Year)
	η		30. Name and address of person who completed cause of death Dr. William Bencens 244	(Item 23a) (Type,	Or: #100	Anna	Polis, M.	0 21401	0
	Sta Registr		31. Date filed (Month, Day, Year) Registrar's S	Signature	and s				

	1 - For		Department of Health as Certificate of Death	nd Mental Hygie	ng nns 35053
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Physician				Month	Day Year
/Medica			Ab City Tayer and analism of	October	
Examine	Fort Washingto		4b. City, Town, or Location of		4c. County of Death
		Sex 7. Age (In yrs. last b	Ft. Washing		Prince Georges
Funeral Director	577-24-0439	18 M 2 □ F 85		Min. (Month, Day, Ye	
	Usual Residence of Decedent	0.0		July 4,19	21 Louisa, Va.
ylan ylan	10a. State 10b. County	10c. City, Tox	wn or Location		10d. Inside City Limits
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% h the	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
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	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican,		14. Race - American Indian,
ال هو الله	1 Never Married 2 Married		1 ☐ Yes 2 ☐ No Specify:	dello filoan, etc.)	Black, White, etc.
15.0036 15.0036 7 - 4 - 24 72 hours after death with the Marylar nature!; or Items 238 or 286-f show added exemples must be notified at least his Entered Director	3 Widowed 4 Divorced	Year or Dates:	•		Specify: Black
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	23a. Part1. Enter the disease, or co	mplications that caused the death. Do	not enter the mode of dying, such as ca	rdiac or respiratory arrest,	Approximate
Physician	Immediate Cause (Final	y one cause on each line.			Intervat Between Onset and Death
/Medical	disease or condition resulting in death)	a A (ME)CO3CI	LEROTIC CARDI	OVASCULARCE	DUEITSE
Examiner		8	51).		
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8760, sate be exchysician at the burial.		d			
P.O. Box 68 hat the death certifica dby the attending phetached for use as it Physician/Med	IF FEMALE:				
Box sath cert attendin for use.	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death			23d. Date of delivery Month Day Year
O. l ob en the s shed the	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)		54,
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Division of Vital Records, to Attending Physicien: The law requires to after death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	2 Accident Investigati 3 Suicide 6 Could not	be 300 Blace of lains, At home 6			and Number or Rural Route Number.
Division c let or Attending P s after death. el Director: After t ed in by the funers Certification:	4 ☐ Homicide determine	building, etc. (Specify)	and the state of t	City or Town, Sta	ate)
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he Hosp in 24 hou he Fune pletely fii	one)	miner: On the basis of examination are and manner stated.	nd/or investigation, in my opinion, death	occurred at the time, date a	and place, and due to the cause(s)
To the within to the company of the	29b. Signature and title of partifier	0	29c. License number	4000000	Date signed (Month, Day, Year)
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Tu		completed cause of death (Item 23a)			11 10 1
[7]		MESE, 11701	LIVINGSTON &	DAD SUTE	# 101, FORT WASK
State Registrar	31. Date filed (Month, Day, Year) OCT 3 0 2006	32. Registrar's Signature			MD
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8	Physicia	an	Decedent's Name (First, Middle Trail 1								Date of Deat Month	Day	Ye		3. Time of Death
	/Medic	al	Vallie B. Wal		mher)		4b. Cit	v. Town. or	Location of De	_	ctober		20 county of 0		12:46 A ^M
	Examin	er	Barbie Ass						lenn D						George's
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Und	er 1 Year	If Under 24 H		Date of Birth (Month, Day,		9.	Birthpla	ace (State or Foreign
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	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10	d. Inside City Limits
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	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or itema 23a or 28a-f ehow event, the Modical Examinar moral be notified at	Funerai	11. Marital Status	Armed F		I.S. 13.	Was Dec	edent of His ecify Cubar	panic Origin? I, Mexican, Pu	(Specify erto Ric	y Yes or No- an, etc.)	14	1. Race - / Black, V	Vhite, e	tc.
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Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: If term 27 is marked other than "natural; or theme 23a or 28a-f show any injury or other traumatic event, the Medical Examinat navit be notified at once.		Peggy P. St								Mitche	-			20720
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<u>=</u>	permit. Depertra Importe any Inju		21. Signature of Funeral Service	Licensee	+			and Address			wart F	uner	al Ho	ome	
<u> </u>	89 = 8		Voho	wilk.	or Th		40	01 Be	nning l	Rd.,	NE W	ash.	, DC		
			23a. Part1. Anter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea each line.	th. Do not ent	er the m	ode of dying	, such as card	diac or re	espiratory arri	est,			Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	а	Congesti		rt F	ailur	e					4	
	/Medical Examiner				o (or as a consec		_								
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Atheroso (or as a consec		.S								
	outed ansit	Examine	Cause (Disease or injury that initiated events	S c											
Š	e exection er	Ex	resulting in death) Last	Due to	(or as a consec	quence of):									
2/PU	cate be executed physicien end the burial-transit	dical		d											
×	certific nding p	0	IF FEMALE:	23c. If yes, o	utcome of pregn	ancy						23	3d. Date of	f deliver	v
ğ	that the death certified by the attending I detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live	birth 2 Feta	al death 3	Ectopic Other	pregnancy (specify)					Month		Day Year
ָכ	t the d	hysi	9 Unknown	9□ Unk	nown										
ω̂ L	requires that been signed b hould be deta	by P	Part II. Dther significant condition	ons contributing to	death bul not re	sulting in the u	inderlyin	g cause give	n in Part I.						e cause of death?
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0	aw 2 s t	Completed								_	24a. Was a autops	y	24b. Wer prior deat	e autop	sy findings available apletion of cause of
	Pa ete											2 X No		Yes :	2 □ No
VIII	Physiclan: Th this certificete ral director, pag	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hocoital:	Inpatient 2	TER/Outpation	at 2 🗆	Othe	-		5 🗌 Reside		₹7Othetr (Snatihi) 1 T d - d
0		-	27. Manner of Death	28a. Dat	e of Injury	28b. Time o		28c. Injury Work			d. Describe ho			551'8	ted Living
<u> </u>	Attanding Fir death.	atio	1 Anatural 5 ☐ Pendir 2 ☐ Accident investi	9	nth, Day Year)	Injury	М		es 2 □ No						
UNISION	r Atta	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 286. Plat	e of Injury - At h	nome, farm, st	reet, fact	ory, office		28f	Location (St City or Town		Number o	r Rural	Route Number,
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	To the Hospital or Attandi within 24 hours after death To the Funeral Director: / completely filled in by the fi	ledicai		ng Physician: To the Examiner On the and ma											
	vithin 2 fo the	Me	29b. Signature and title of certifie	//				29c. License	number		2	9d. Date	signed (A	fonth, E	Day, Year)
	->-0		•						MD2098	5		Oct	ober	26.	2006
) ,	16		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type,	Print)								
				P. Ander	son, M.I	106	Ir	ving S	t., NW	, St	e. 314	S W	lash.	, DO	20010
1	Sta Registi		31. Date filed (Month, Day, Year)	Baren	Registrar's Sign	South									

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 36055 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 27, 2006 **Physician** 6:05 P M WARD **TAMARA** Т. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerset. Crisfield McCready Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth (Month, Day, Year) Oct. 8, 1949 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🕱 F Yrs 216-54-9937 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Crisfield Maryland Somerset Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21817 U.S.A. 310 Myrtle Street death y Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, I'm Medical Examination. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ð 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Iva Jean Lawson Carlton Lorenzo Tawes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 310 Myrtle Street - Crisfield, MD Rick Ward (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/31/06 Salisbury, MD Salisbury Crematory * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw, Jr. 306 W. Main St.-Crisfield, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MINS Immediate Cause (Final Concluse Christ **Physician** disease or condition resulting in death) /Medical materi Heart Failure **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine YX certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the l IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 1 ☐ Inpatient 2 ▼ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑No this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t Certification: 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the I within 2. To the F 29c. License number 29b. Signature and title of certifier D10688 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Type, Print) Gastun Hune Drure Word, Dimalel M. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 2 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Blanche Dorsey Winters 24,2006 8:45AM October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner La Plata Charles 8550 Penns Hill Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2**X**)F Director 93 October 2,1913 Maryland 214-36-3664 Usual Residence of Decedent with the Maryland 10c City Town or Location 10d. Inside City Limits 10a State 10h County ral', or Itema 23a or 28a-f ehow Example must be notified at 1 Yes 2 No La Plata MD Charles Director 10q. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Itema 23e eny Injury or other treumatic event, If a Medical Experiment once. 8550 Penns Hill 20646 USA Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black X☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Joseph Bradley Martha Annie Baker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph Dorsey/Son 8550 Penns Hill Rd.La Plata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Mary's Newport Cem. 10/28/06 Charlotte Hall, MD M00945 AREHART-ECHOLS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee St. Mary's Ave. La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Examiner Due to (or as/a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 MNo 1 Yes After this certification 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; 1 Natural
2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No investigation death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) filled in by 4 Homicide hours after within 24 hours a 1x Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10123106 D21031 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Leatherwood, M.D. 12070 Old Line Center, Ste. 302, Waldorf, MD20604 31. Date filed (Month, Day, Year)
OCT 2 gistrar's Signature State 2006 Registrar

			1 - For State Registrar	State of Ma	aryland / I		irtment of He tificate of D		Mental	Hygien Reg. N		3605/
ï	Physici	an	Decedent's Name (First, Mid						2. Date of	Da	ay Yea	3. Time of Death
1	/Medic Examin		4a. Facility Name (If not instituti	on, give street and number)	>r		4b. City, Town, or I	ocation of Dea	10ct	24	c. County of Di	
	Funeral Director	er	T. I. N. W.	yland Medicul	Center e (In yrs. last bil 46	rthday) Yrs.	Baltimer If Under 1 Year Months Days		8. Date o		9. E	Birthplace (State or Foreign Country) Maryland
	and *		Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City, Tow	m or Loc	ration					10d. Inside City Limits
	deeth with the Maryland me 23a or 28a-f ehow I must be notified at	ō		cester	Snow							1 Yes 2X No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What	Country?
	th witi	alD	6633 McCabes	Corner Road			21863			U	.S.A.	
36	be filed within 72 hours after deeth with the Marylan lat Hygiene. d other than "neturel", or Iteme 23s or 28s-f ehow event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Never	If Yes Give			Vas Decedent of His Yes, specify Cuban ☐ Yes 2 No	panic Origin? (S , Mexican, Puer Specify:	Specify Yes o to Rican, etc.	r No-	14. Race - Ar Black, W Specify:	merican Indian, hite, etc. white
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anc		o Be	Ralph James V					18. Mother's Na Chris	tine L		n Sumame)	
چ	d 2 should th and Men 7 le marke traumatic	은	19a. Informant's Name/Relation		198	. Mailin	g Address (Street ar				or Town, State	a. Zip Code)
	d 2 le 17 le		Christine Wel	ls (Wife)			3 McCabes				H111, N	
Baltimore,	-155		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	a 3 □Removal from State	Spence	ry, crem Rat	sition (Name of patory or other place, ptist	1	Date		ocation - City	
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				or complications that caused	the death. Do	1	3 E. Grov	e St.	Delmar		19940	Approximate
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C. Box	he death certificate be executed the ettending physician and ched for use as the buriat-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)			- 10,0	23d. Date of o Month	delivery Day Year
ecords, P.	w requires that the de been signed by the should be detached	ρ	Part II. Other significant condi	tions contributing to death b	ut not resulting i	n the un	derlying cause given	in Part I.			use contribute	to the cause of death? Probably 4 □Unknown
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	ding After fune	atlon:		tigation	ry Year) 28b. 1	Time of Injury	28c. Injury a Work? M 1 🗆 Ye	at es 2 □No	28d. Descr	ibe how inju	iry occurred	
DIVISION	7 2 2 2	Certification;	3 ☐ Suicīde 6 ☐ Coule 4 ☐ Homicīde deter	d not be mined 28e. Place of Inju- building, etc	ury - At home, fa c. (Specify)	ırm, stre	et, factory, office		28f. Locatio City of	on (Street a Town, State	nd Number or e)	Rural Route Number,
	To the Hospitel or within 24 hours ef within 24 hours ef To the Funeral D completely filled in	edical	29a. Certifier 1 Certify (Check only one) 1 Medica	ing Physician: To the best il Examiner: On the basis of and manner sta	examination an	deeth	estigation, in my opin	date and place nion, death occu	and due to urred at the ti	tt e cauco(c me, date an) and manner d place, and d	as stated. ue to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certif	ier // C			29c. License	number		29d. Da	ate signed (Mo	nth, Day, Year)
	00		▶ William	K Chu D(2		PI	4680		100	7 25	,2006
/	M		30. Name and address of perso	n who completed cause of d	eath (Item 23a)	(Type, P	1.0 + 4	4. 1	2120	1		
	Sta	te	31. Date filed (Month, Day, Yea	r) 32. Registra	orleng ar's Signature		1 baltimor	e Mol	2120	1		
	Registr			7 2006 Blow	ar's Signature	60	ale					

	1	For State Registrar	State o	f Maryland		artment tificate				Re	g. No.	006	36058
Physicia	เก	Patricia	Last)		Wen	ze/	•			2. Date of Death Month October	Day	Year CCC	3. Time of Death //-'25 M
/Medic Examin	er 4	a. Facility Name (If not institution, of The Johns Hopking)	· Hospi	tal		•	Smo	Location of	1/2	8. Date of Birth	4c. Coun	ty of Death	n nplace (State or Foreign
Funeral Director		5. Social Security Number 490–50–7122 Usual Residence of Decedent	Sex 1□M 2⊠F	7. Age (In yrs. I	Yrs.	Months	Days	Hours	Min.	(Month, Day, July 27	Year) 1947	Col	ginia
of show		10a. State 10b. County MD Wicom	ico		ebron	ocation							10d. Inside City Limits 1 ☐ Yes 2 No
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lat Hygiene	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Dec Armed F	2∰ No ive		Was Deced If Yes, spec	dent of Hi			cify Yes or No- Rican, etc.)	14. R	ace - Ame lack, White	ncan Indian, a. etc. hite
an "natural Mudical Es	Completed t	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed		(Give	dent's Usua kind of wo DO NOT us	rk done d se retired	lurina mos	t of workir		16b. Kind of		Industry Maryland
tal Hygi d other event, 1	Be	12 17. Father's Name (First, Middle, L	ast)		Jones	ns Tal	ker			(First, Middle, I			Unknown
2 should and Men ie marke raumatic	ဥ	Waco 19a. Informant's Name/Relationsh		1	19b. Maili	ing Address		and Numb		l Route Number			Zip Code)
Heal Heal ther		Herbert Wenzel 20a. Method of Disposition 1 ③Burial 2 ☐ Cremation	3 □Removal from	n State	lace of Disperentery, cre	osition (Na matory or o	me of other plac	e)	D	Hebron,	20c. Locatio	n - City or	
permit. Pages Department of importent: If It any Injury or o		4 Donation 5 Other (Sp		Не		2. Name a	nd Addres	ss of Facili	by Bo	unds Fur Salisbu	neral	Home	40
hysician		23a. Papri. Enter the disease, or o shock, or heart failure. List of immediate Cause (Final disease or condition	complications that	caused the deat									Approximate Interval Between Onset and Death
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th. : After this s funeral d	tlon: To	27. Manner of Death 11. Natural 5 Pendin 2 Accident investig	28a. Da (M	te of Injury onth, Day Year)	28b. Time Injury	of	28c. Inju Wo	ry at rk? Yes 2[]No	28d. Describe h	now injury od	curred	
to the nospital of Avenous and whiting A hours effect death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 200. Fit	ace of Injury - At hilding, etc. (Special	ify)					City or Tox	vn, State)		Rural Route Number,
24 hours e	edical	29a. Certifier Certifyir (Check only one) 2 Medical	g Physician: To Examiner: On the and m	the best of my kn a basis of examin anner stated.	ation and/or	investigation	d at tha to on, in my	me, date a opinion, de	and place. eath occur	and due to the red at the time,	Gate and pla		
within 2 To the Complet	Me	29b. Signature and title of certified	ML	M.D.		2	9c. Licen	se numbe	DT	0		-	nth, Day, Year) 5,2006
my		30. Name an address of person	HUH~						otodis-	(Saltim	v.Wol	5,2006 15/5+ 7021201
S Regis	tate trar	24 Date Glad (Month Day Vear	7 2006	2. Agistrar's Sign	nature	Spark	()						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per me 8861 11-15-06 yt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician /Medical 4b. City Town, or Location of Death acility Name (If not institution, give street and number Examiner 2000 8. Date of Birth (Month, Day, Yea Sept. 22, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Forg 7. Age (In yrs. last birthday, Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M Sept. Maryland 21 1985 215-17-6313 Director Usual Besidence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Glenwood Director Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21738 U.S.A. 2720 Hobbs Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽŽNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 🔏 Specify Specify. White Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) Secretary Accountant marked other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental I Be Department of Health and Mental Important: If item 27 is marked or any Injury or other Mark Joseph Ashby Sherri Stoner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenwood, Maryland 21738 2720 Hobbs Road Sherri Ashby mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State West Arundel Crematory 11/14/06 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 200maidsdffssffafferal Home, P.A. M00770 20707 Laurel, Maryland 313 Talbott Avenue Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 7/2 **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): N WEDDON'T EXAMINER Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) OF RTIFICATI Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No ed by the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but-not resulting in the underlying cause given in F 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate 1 Yes 2 No Division or Vital To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 1 Yes 2 No 5 Residence 6 □Other (Specify) 1. Amatient Certification: To 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death SZAM 1 Natural 5 Pending investigation ON FOOL TABLE 2 No 1 ☐ Yes 2 Accident Suicide 6 ☐ Could not be Place injury - At hon building, etc. (Specify) Number or Rural Route Number At home, farm, street, factory, office Location (Street and City or Town, State) 28e determined HOBBS ROAD 4 Homicide 1 Aertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of exa and manner stated/ mation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 12 No. License number 29d. Date signed Month, Day, Year) 29b. Signature and title of certific e of death (Item 23a) (Type, Print) Dikizan Registrar's Signature 32. State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 005

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			1 - State Registrar			Cei	rtificate of	Death		Reg. No.	, , ,	0000
	Physici /Medi		1. Decedent's Name (First, Mic		ALLMONI)			2. Date of D Month NOVEMB	ER 8,	Year 2006	3. Time of Death
	Examir		4a. Facility Name (If not instituted 6128 Surrey S	quare Lane	#103	to an trimbooks of	4b. City, Town, Forestv If Under 1 Year	ille		Princ		orge's
	Funeral Director		5. Social Security Number 578-64-1479 Usual Residence of Decedent	6. Sex 1 X M 2□F	7. Age (In yrs.)	Yrs.	Months Days		vlin. (Month, D	Pay, Year)	E11t	place (State or Foreig intry) per NC
	th the Maryland or 28a-f show e notified at	Director	10a. State 10b. Cour MD Princ 10e. Street and Number	e George's		y, Town or Lo	1e 10f. Zip Code			10g. Citizen o	of What Cou	
e, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral	(Specify only high Specify only high Specify only high Elementary/Secondary (0.12 12 17. Father's Name (First, Midd David Allmond 19a. Informant's Name/Relation Margaret Allmod	12. Was Dec Armed F 1 1 2	vedent Ever in U. corces? 2 No 10/ 2 No 7/6 vedents: 7/6	16a. Deced (Give life. L Corre	dent's Usual Occur kind of work done DO NOT use retin ctional	o Specify: Ipation of during most of ed) Officer 18. Mother's Lillia of and Number of St Oxo	Name (First, Middle	B Special Spec	ace America Am	ican Indian, , etc. ck ndustry vernment ip Code)
Baltimore,	permit. Pages 1 Department of H Important: If Itel any Injury or otl		20a. Method of Disposition 1 Surial 2 Crematio 4 Donation 5 Other 21. Signature of Funeral Servi	(Specify) ce Licensee	Mar Cem	yland etery ²² 2	617 Penn	ress of FacilityP	/17/2006 Ope Funer Washingt	Chelte cal Home ton DC 2	enham	,
68760,	Physician //Medical Examiner physician and physician physician physician physician with physician physicia	/Medical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CARD Due to DIAB Due to POST	(or as a consequence of the cons	THY uence of): LLITUS uence of): TIC ST			EPRESSION			Approximate Interval Between Onset and Death
P.O. Box (that the death certil ned by the attending detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	itcome pf pregna birth 2 Feta nant at time of d	I death 3	⊒Ectopic pregnan □ Other <i>(specify)</i>	су			Date of delive	very Day Year
or Vital Records, P	e law requires has been sign e 2 should be	Completed by Ph	Part II. Other significant cond	itions contributing to c	death but not resu	ulting in the ur	nderlying cause g	iven in Part I.	1 □	Yes 2 No	3 ☐ Pro	the cause of death? bably 4 Vunknow copsy findings available ompletion of cause of
Division or Vital	ding Physician: After this certific funeral director,	Certification: To Be Co	3 Suicide 6 □ Cou	Hospital: 1 28a. Date (More than 1) 4 not be 28e. Place 28e. Pla	nth, Day Year)	28b. Time of Injury	f 28c. Inj	ther: 4 Nursii ury at ork? Yes 2 No	28f. Location	one) sidence 6 C	urred	zX No ify) ral Route Number,
	To the Hospital or Attention within 24 hours after death within 24 hours after death To the Funeral Director.	Medical ((Check only one) 2 Medic	The Sa	basis of examina nner stated.	tion and/or in	vestigation, in my 29c. Licer	time, date and propinion, death ase number 18136	occurred at the time	e cause(s) and e, date and place 29d. Date sign	e, and due	to the cause(s)
	St. Regist		30. Name and address of persipametra STEELE, 31. Date filed (Month, Day, Ye.	M.D., VAM	se of death (Item C 50 IRV Registrar's Signa	ture	CREET NW	, WASHII	NGTON, DC	20422/6	88	

			For State Registrar	State of N	Maryland		artmen rtificat					giene (006	36061
			1. Decedent's Name (First, Middle, Las								2. Date of De.		Year	3. Time of Death
	Physici /Medio		Marvin 3). Al	binak _,	Ph.D					Novembe	r 12,	2006	4:50 a M
E.	Examin		4a. Facility Name (If not institution, give		or)		4b. City,	Town, or	Location	of Death			ounty of Death	
			Manor Care-Ruxto					Tows		O4 Neo			Baltimo	
	Funeral Director		5. Social Security Number 6. Social Security Number 1	9X 2□ F 7.7	Age (In yrs. Ia 78		Months	Days	If Under Hours	Min.	8. Date of Bird (Month. Da June 21	ÿ, ^y • 1 92	B Mic	olece (State or Foreign ntp) Chigan
	pu		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Aarylë Faho ed a	ō		imore		Tows								1 ☐ Yes 2/XNo
	the 7	rect	10e. Street and Number				10f. Zip	Code				10g. Citizer	n of What Cou	ntry?
	h with	O E	8205 Robin Hood	Court					21 204			U	.s.A.	
	ams 2	Funeral Director	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S	3. 13.	Was Deced	lent of Hi	spanic Ori n, Mexicar	gin? (Spe	cify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White,	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. mportant: If tiem 27 is marked other than "netural", or itams 23a or 28a-1 show my rigury or other traumatic event, the M. dical Examiner must be notified at 2008.	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 [If Yes, Give Year or Date:			1 ☐ Yes		Specify:				pecify:	Jhite
2	72 ho	eted	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usua kind of wo	rk done d	lurina mos	t of worki	ng	16b. Kind	of Business/In	dustry
21215-0036	within lene. then "	Completed	Elementary/Secondary (0-12)	College (1-4c	r 5+)	life.	po not us Fesso:	se retired)			Co	llege	
<u>0</u>	be filed Ital Hygi od other event, I	Be Co	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,	Maiden Su	ımame)	
Baltimore, Maryland	should be and Menta s marked umatic ev	To B	Alfred	Al	binak	1				heri			Smu]	
Man	12 sho		19a. Informant's Name/Relationship (7) Anne-Elizabeth Al		uahter								own, State, Zip D 2121	_
e,	permit. Pages 1 and 2 Department of Health a Important: If tem 27 ti any injury or other tra QDC®.		20a. Method of Disposition	DITION GG	20b. Pl	ace of Dispo	sition (Nan	ne of			ate	<u> </u>	tion - City or To	
ы	ages ant of at: If it y or o		1 Bunal 2 Cremation 3 C 1 Donation 5 Other (Specify		10	metery, crei			θ)	11/	15/06	Timo	nium, M	√ D
⊒ E	antime portar		21. Signature of Funeral Service Licen						s of Facili					ome, Inc.
ä	Depar Impo		Mille								wson, M		204	
	Physician /Medical Examiner	iner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. DEM Due to (or a	as a consequence as a c	ence of): C	Z 2	ALT	ZHE	EIM	ER'S	74	ipe	Interval Between Onset and Death
8760,	cate be executed physician and the buriat-transit	lical Examin	Cause (Disease or injury that infitted events resulting in death) Last	c	as a consequ	ence of):								
O. Box 6	death certifi e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknowr	2 Fetal at time of de	death 3[Ectopic pr					230	d. Date of deliver	ery Day Year
ds, P.	es De de	by	Part II. Other significant conditions o	ontributing to death	but not resu	lting in the u	nderlying c	ause give	en in Part I			obacco use Yes 2 🗆 f		he cause of death?
Records,	e law requir has been si je 2 should	Completed									24a. Was	an 2 osy rmed?	24b. Were auto prior to co death?	opsy findings available impletion of cause of
E H	Th ate pag	ပ်									1 ☐ Yes	2X No	1 🗆 Yes	2□ No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	ar 1/		(Check only o		701-1/2	
o	Phys r this ral dii	1: To	1 Tes 2 No 27. Manner of Death	28a. Date of li		28b. Time o		28c. Injury Work	4 NI		ne 5 ☐ Reside l		Other (Special occurred	(y)
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Certification:	Section Sect	28e. Place of	Injury - At horetc. (Specify	Injury me, farm, str	М	1 🔲 '	k? Yes 2□		28f. Location (City or Tox		Number or Rura	al Route Number,
	Hospital 24 hours a Funeral l etely filled	edical C	29a. Certifier Check only one) Certifying Ph	ysicien: To the be niner: On the basis and manner	of examinati	wledge, deat ion and/or in	h occurred vestigation	at the tim	ne, date ar pinion, dea	nd place, a	and due to the ed at the time.	cause(s) an date and pl	nd manner as s ace, and due to	stated. o the cause(s)
		Me	29b. Signature and title of centilier	delm			290	C. License	e number	284	iq	29d. Date s	igned (Month,	Day, Year)
	10		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print) 954	EK	0 7	s	TOWSO	NI	13-0 7D Z	1204
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regi	strar's Signat		- 1	A						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 12:50 P.M BRADFORD November HENRY 11,2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) 8. Date of Birth (Mogth, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F Social Security Number **Funeral** Months Davs Hours 58 Yrs. 215-46-6428 MARYIAND 22/194 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21202 305 W. MONUMENT STREET Apt 312 Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 by Yes 2 □ No / 2/65 If Yes, Give Year or Dates: / 2/68 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If item 27 is marked other that any Injury or other transment. NURSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (WILLIAM EDMONDS BRADFORD ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, MARYLAND SISTER BRYANT AVE., HARRIETT BUSH 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 11/20/2006 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State MARYLAND FOREST CEME 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility THE DERRICK C. JONES 21. Signature of Funeral Service Licensee 4611 PARK HOTS. AVE., BALTIMERE, MARYLAND 23a. Fart1. Enter the disease, or comp shock, or heart failure. List of ly cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 20 4RS Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal de use 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 ☐Ectopic pregnancy Month Day Year Po 5 Other (specify) 4 ☐ Pregnant at time of death ☐Yes 2☐No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 pe 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an was u... autopsy performed Yes 2 page 2 certificate 1∐ Yes within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 2 ER/Outpatient 3 DOA 1 🔲 Yes 1 Inpatient Δľ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of De M Injury Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Check only Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chec To the within 2

State Registrar 20b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

NOV 1 5

2006

DHMH 17 Rev 1/2001

ORIGINAL

29d. Date signed (Month, Day, Year)

Douglas Lee Baer, III

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 36063

		1- For State Registrar	Cer	tificate of	Death			Reg No.	
Physicia dical Exami	an/	Decedent's Name (First, Middle DOUGLAS	e,Last) LEE BAEF	R I	II		2. Date of Dea Month Novembe	oath Day Year er 14, 2006	3. Time of Death 0539 hrs
		4a. Facility Name (if not institution Bay Bridge	on, give street and number)		4b. City, Town, or Lo Annapolis	ocation of Deat	h	4c. County of Do	
Funeral Director		5. Social Security Number 217–08–4579	6. Sex 7. Age (In yrs. la	nst birthday) Yrs	If Under 1 Year Months Days	If Under 24Hr Hours Mir		irth (MM/DD/YYYY) 9. 21,1983	Birthplace (State or
5-0036 4-0036 5-0036 5-0036 5-0036 6-0056	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Ann 10e. Street and Number 712 Partridg 11. Marital Status 1 Never Married 2 M 3 Widowed 4 Div 15. Decedent's Education (Spe Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle Douglas 19a. Informant's Name/Relations	te Arundel 12. Was Decedent Ever in U.3 Armed Forces? 1 Yes 2 No Vorced If Yes, Give Year or Dates. cify only highest grade completed) College (1-4 or 5+) 0 Lee Baer Jr. ship (Type, Print)	Town or Locat Glen S. 13. Wa ffy 1 1 16a. Deceder during m	Burnie 10f. Zip Code 21 s Decedent of Hispares, specify Cuban, It Yes 2 No No No No No Warehous: Address (Street a	Mexican, Puerto specify: n (Give kind of DO NOT use reteman B. Mother's Nam Ruby and Number or	specify Yes or No or Rican, etc.) work done tired) e (First, Middle, Christ Rural Route Nu	U.S.A. O- 14. Race - Ar White, et Specify: 16b. Kind of Busine Office S Maiden Surname) ine Johnso	10d Inside City Limits 1 Yes 2 No Country? merican Indian, Black, c. White ss/Industry Cupply Company on tate, Zip Code)
Baltimore, MD 2121, permit Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event,	21. Signature of Fundral Service Licenses 22. Name and Add MCCUI Ly- 3204 Mot						Date -18-06	Maryland 2 20c Location - City Glen Burn Home P.A. dena, Mary	y or Town, State
Physician /Medical ⁻ xaminer	/	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	Do not enter t	he mode of dying, si	rest, shock, or heart	Approximate Interval Between Onset and Death		
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of c. Due to (or as a consequence of	f):					
8760, tificate be executed mg physician and as the burial - trans	n/Medical	UNPENDED	d AMENDED						
Box 68760, he death certificate be the attending physicial hed for use as the burn	Physician/M	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	he 23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of de	2 Fe	etal death 3 her (Specify)	Ectopic pregn	ancy	23d Date of deli Month	very Day Year
ords, P.O. E w requires that the c as been signed by the should be detached	by	Part II. Other significant condi	tions contributing to death but not re	esulting in the i	underlying cause giv	ren in Part I		tobacco use contribute	e to the cause of death? Probably 4 Unknown
Rec The la cate ha	performed? death								
Vital I hysician: this certifi I director.	o Be	25. Was case referred to medica examiner?	Hospital: 1 Inpatient 2	ER/Outpatient		thor:	ing Home 5	Residence 6 🗸 0	ther: Scene
on of V ending Phy eath. or: After th	-		28a Date of Injury (Month, Day Year) Nov 14, 2006	28b. Time of I 0356 hrs	Injury 28c. Injury		28d. Describe	how injury occurred nped from Bay b	
Division pital or Attendio ours after death.	Certification:	3 Suicide 6 Cou	28e. Place of Injury - At horizontal did not be ermined (Specify) Bay Bridge		et, factory, office bui	ilding, etc	or Town,		r Rural Route Number, City
Division To the Hospital or Attenct within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	one) 2 Medical Exa	Physician: To the best of my knowledgaminer:On the basis of examination a and manner stated.	-	tion, in my opinion, e	death occurred		e and place, and due t	o the cause(s)
	Ź	29b. Signature and title of certifications of the Country of the C	er SAC		29c. License O.C.M			November 14	
6		Zabiullah Ali, M.D.	n who completed cause of death (Item Assistant Medical Examiner	111 Per	nn Street, Baltin	nore, MD 2	1201		
	tate	All IVE I b	2006 32 Registrar's Signatu	re Agos	Miller				

06-06970 JENNIFER LYNN BLANKBASHIP UNK UNK

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 36064

		1- For State Registrar		Certific	ate of	Death		R	eg No	,00 0300
Physici		Decedent's Name (First, Middle,La	Month Day Year							
ledical Exami	ner			ship				Septembe	er 15, 2006 "	1615 hrs
		4a Facility Name (if not institution, g In field off Boyer Lane	ive street and number)		41	o. City, Town, or Li Aberdeen	ocation of De	eath	4c. County of Harford	of Death
Funeral		Social Security Number 6.	Sex 7 Age	(In yrs last bir	thday)	If Under 1 Year	If Under 24	Hrs 8. Date of Bi	rth(MM/DD/YYYY	
Director		225-23-7293 1	M 2 F 2	26	Yrs.	Months Days	Hours !	Min 7.14	,1980	Foreign Country) W . VA
		Usual Residence of Decedent				l			,	W · VA
any		10a State 10b. County		10c. City, Town				_,		10d. Inside City Limits
rland -f show once.	_	MD Harfor	·d	Abe	rdee	n				1 Yes 2 No
rlaryland 28a-f show 1 at once.	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wh	at Country?
the M a or 2 tiffed	Ö	22 Spesutia R	load			21001			U.S.A	
with the ns 23a	<u>ra</u>	11 Marital Status	12. Was Decedent E	ever in U.S.		Decedent of Hispa		Specify Yes or No	14 Race	- American Indian, Black,
death r iter	Funeral	1 Never Married 2 Marrie		₹ No	If Yes	s, specify Cuban, I	Mexican, Pue	erto Rican, etc.)	White	
after al", o	by F	3 Widowed 4 Divorce	d If Yes, Give Year or Dates:		1 \	Yes 2 X No	specify.		Specify:	White
2 hours afte "natural", Examiner	be	15. Decedent's Education (Specify	only highest grade comp			s Usual Occupation			16b. Kind of Bus	siness/Industry
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0036 within 72 jene ner than '	щć	12		C	ashi					
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21215-0036 Uld be filed within 7 Mental Hygiene marked other than	To Be	Lewis Robert B	Type Print)	LP 19	h Mailing	Address (Street :	ucy c	Jane Str or Rural Route Nur	eet	Chate 'Zin Cada'
MD 2 d 2 shou lith and N n 27 is r	-	Lucy Jane Stre						Aberdee		
and 2		20a Method of Disposition				on (Name of ceme		Date		City or Town, State
Baltimore, MD 21215-003 Departit Pages I and 2 should be filed within the filed within the filed of the filed		1 Burial 2 Cremation 3		Ches	tory or othe	ke Crem	. 11	.10.06	Reltsv	ille, MD
Itimer Program or tan		4 Donation 5 Other Specifical Signature of Funeral Service Lice		1 01100	-					•
Balt permit Departs Import injury		2 0 0-	11. Mr	111112	22 140	4 7 A	Cr	ematior	i And F	uneral Balto
Physician		23a Pan I. Enter the disease, or con	ications that caused t	he death Do n	ot enter the	I/ Gree mode of dying, su	en Pas uch as cardia	c or respiratory arm	or. Alte	ermatives MD Approximate Interval
/Medical		failure. List only one cause on	Pan I. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest allure. List only one cause on each line.							Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec							
J.		Sequentially list conditions,)							
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consec	quence of):						
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8 5-1	Physician/Medical	X UNPENDED	#23a, 27,28	Ra-f nor	MF ~Q	66 1/6/07	יויי			
8760, tificate be en mg physicia as the buria	Me	IF FEMALE:	23c. If yes, outcome	e or pregnancy			11		23d Date of c	delivery
68 certifi ding se as t	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at to	and the state of t	Peta		Ectopic preg	gnancy	Month	Day Year
Box e death of the atter	/sic	1 Yes 2 No 9 Unknow		ine or death	5 Othe	er (Specify)				
O. Enat the condition of the condition of the ctached	P.	Part II. Other significant conditions	contributing to death	but not resultin	g in the un	derlying cause give	en in Part I	23e. Did to	bacco use contrib	oute to the cause of death?
, P.O. Box 6 res that the death cer signed by the attendible deducted for use	by							1 Yes	2 No 3	Probably 4 🗸 Unknown
cords, faw requir has been s	Completed							24a Was		/ere autopsy findings available
COI e faw e has l	d d							autop perfor		for to completion of cause of eath?
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ital siciau: s certif irector,	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatien	+ 2 EB/O	utpatient		f Death (Che		Dealds and C. 4	
n of Vi ling Physic After this funeral dir	: To	1 Yes 2 No 27. Manner of Death	28a Date of Injury		Time of Inju	o bon	4 110		Residence 6 V	
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ivisior or Attence after death Director:	icat	2 Accident Investiga	28e Place of Inii		d 4:15	factory, office buil	Idina, etc.		Street and Number	r or Rural Route Number, City
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Hospi 4 hou Fumer ely fil		29a Certifier	cian: To the best of my			d at the time date	and place a			
D To the Hospital Within 24 hours To the Funeral completely filled	Medical	one) 2 • Medical Examina								
. 4 3 4 8	Me	29b. Signature and title of certifier	and marrier stated			29c License r	number		29d Date signer	d (Month, Day, Year)
		famet Karth 1.11	m()			O.C.M.	.E.		September	16, 2006
		30. Name an ress of person with	completed cause of de	ath (Item 23a)						
Pamela Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
	ate	31. Date filed (Month, Day Year) 5	32. R strar	s Signature	1	16				
Regis	trar	MOA T 9	TAND TO SEE	W St.	1075					

			For State Registrar	State of Mar		artment of F ertificate of			Reg. No.	16	36065
	Physicia		1. Decedent's Name (First, Middle,	3000/is				2. Date of De.	Day	Year 2006	3. Time of Death
F	/Medic Examin		4a, Facility Name (If not institution, g	ive street and number)	100	4b_City, Town, o	or Location of De		4c. County	of Death	
₩.	Funeral Director			Sex 7. Age (I'in yrs. last birthday 74 Yrs.) If Under 1 Year Months Days			th y, Year) , 1931	Cour	place (State or Foreign http) y Land
	yland now		Usual Residence of Decedent 10a. State 10b. County		Ioc. City, Town or L					1	0d. Inside City Limits
	he Mar 8a-1 st pulfied	Director	MD Baltim	ore	Balt	imore			10g. Citizen of V	What Cour	1 ☐ Yes 2X No
	h with t	ai Dir	10e. Street and Number 2813 Kilbaire D	rive			21234		US		,
36	72 hours after deeth with the Marylend natural; or Itama 23a or 28a-f show ural Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1	er in U.S. 13.	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No		(Specify Yes or No erto Rican, etc.)	Blac	e - Americk, White,	
Maryland 21215-003	2 should be filed within 72 hours after deeth with the Marylen and Mental Hygene. Is marked other than "naturat", or Itama 23e or 28e-f show aumatic event, the Marolcal Examiner must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of w	vorking	16b. Kind of B	usiness/In	,
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ylar	should be Ind Mental in marked o	To B	James Burton		401-14	F. Add. (2)		ele Hamar		Ctata Zia	Codel
Z Z	カルトナ		19a. Informant's Name/Relationship Robert Borkowski			ling Address (Street 1 $\mathtt{Cliffva}$				2123	
altimore,	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☒ Donation 5 ☐ Other (Spe	cify)	20b. Place of Disp			Date	20c. Location -	City or To	own, State
Balt	permit. Departimport. sny inj		21. Signature of Edneral Service to	Wade Dire	ctor s	State And State And Baltimore		ard 655 W 1201	. Balti	more	Street
Ė	*		23a. Pant. Enter the disease, or conshoots, or heart failure. List or	omplications that caused the	ne death. Do not e	nter the mode of dy	ing, such as card	iac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	consequence of):	y tan	lure			+	
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oʻ	cate be executed physicien end the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Sual Due to (or as a	consequence of):	ell 96	PRICE	2007			
68760,	ificate b g physic as the bi	edical		d							
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of Vital	Physician: r this certificated director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	t 2 ☐ ER/Outpati	ent 3 DOA	thor	Death Check only		or /Space	6.1
on of	ding Afte tune	tion: To	27. Manner of Leath Natural 5 Pending Accident investiga	28a. Date of Injury (Month, Day		of 28c. Inju			how injury occur		197
Division	the Hospital or Attending 24 hours after death the Funeral Director: Andlessely filled in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		y - At home, farm, s (Specify)	street, factory, office)	28f. Location (City or To		be <i>r or R</i> ur	al Route Number,
	Hospital 24 hours 2 Funeral stely filled	edical C	29a. Certifier 1 CertifyIng (Check only one) 2 Medical E	Physician: To the best of xaminer: On the basis of e	examination and/or	ath occurred at the t investigation, in my	time, date and pla opinion, death or	ace, and due to the courred at the time,	cause(s) and m date and place,	anner as s and due t	stated. to the cause(s)
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)			30. Name and address of persea w	M.D.	ath (Itam 22a) (Ti-	Print) (T/C	6330	C	CILA	ber,	5 2006
			DMITZIY	ne 15 B	altimos	200	1239	Kaven	13180		
100	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	well)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6, 2006 November 7:24 PM M Mary Boyle /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 6, 1935 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F 71 Canada 383-38-3245 May 6, Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.

other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d Inside City Limits 10a. State 10h. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Harford Forest Hill 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2606 Sandy Hook Road 21050 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ∏ Yes 2 MiNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) healthcare registered nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental H Be be Peter Szabo Frances Varga ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2606 Sandy Hook Road Forest Hill, MD John Boyle/spouse item 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of He
Important: If Iter
any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 Funeral Servi Ronal d 655 W. Baltimore Street Director Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NU ean disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine been signed by the attending physician and should be detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy has 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 ☐ Pending investigation 1 Natural Injury 1 TYes death. 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

P.O. Box 68760. Division or Vital Records,

To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu

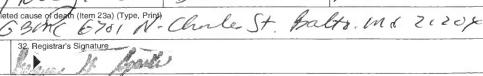
State Registrar

Medical

31. Date filed (Month, Day,

29b. Signature and title of certifier

(Check only



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) l Day 11:40 pm **Physician** 06 rown Yan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE GOOD SAMARITAN NURSING HOME If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. Country, 1 □ M 2 🖺 F JULY 14 1922 Director 84 216-36-6187 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f show Examiner must be notified at Yes 2 No Director BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number IISA 21215 3820 W._ COLDSPRING LANE Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc within 72 hours after 1 X Never Married 2 Married BLACK 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL SECURITY CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fi and Mental F Is marked ot KATIE WILLIAM BROWN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1307 SILVERTHORNE RD. BALTO., MD 21239 Health tem 27 i LORRAINE MORRELL/GODDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If It any injury or o BALTIMORE, MD 11/16/06 NEW CATHEDRAL 22. Name and Address of Facility JAMES A. MORTON & SONS F.G., INC 21. Signature of Euneral Service Licensee ames 1701 LAURENS ST. BALTIMORE, MD 21217 23a. Pakt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence/of): Examiner le Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4**♥**Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s autopsy performe 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 2 ER/Outpatient 3□ DOA 1 Tes this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 2 ☐ Accident s after dea... ral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated.

31. Date filed (Month, Day, Year) State 5 2006 NOV Registrar

29b. Signature and title of dertifier

doch

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 Loch Lower BLVd - I Jahren Will Blud. 32. Registrar's Signature

29c. License number

30

29d. Date signed (Month, Day, Year) NOVEWWL 13 h 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

			1 For State	State of Maryland		nt of Health a	and Mer			36	068
	-		Registrar 1. Decedent's Name (First, Middle, La	st)	Certifica	le oi Dealii	2.	Reg. I Date of Death	No.	3. Time o	f Death
	Physicia /Medic		Mamie G.	Burton				Journapa			LOAM
E	Examin		4a. Fecility Name (If not institution, give Saint Agnes 1)	e street and number)	4b. City	, Town, or Location o	f Death		4c. County of Dea	th	
	Funeral Director		5. Social Security Number 6. S		Yrs. If Under Months	Days Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day, Ye	Thank	thplace (State ountry)	1
	yland	Ī	Usuel Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location					10d. Inside C	
	the Man 28a-f eh	ector	10e. Street and Number	t 1	Saltin	10re		10q.	Citizen of What C		2 🗌 No
	23a or	Funeral Director	1605 St.S	tephen St	-	21216			USI	4	
36	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Deperment of Heelth and Mental Hygiene. Deperment of Heelth and Mental Hygiene Important: if Item 27 is marked other then *natural', or Items 23a or 28a-f show amply injury or other traumatte event, I'm Medical Examinar must be notified at ances.	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	S. 13. Was Dece If Yes, sp	edent of Hispanic Origeoffy Cuban, Mexican 2 12 No Specify:	gin? (Specify i, Puerto Rica	r Yes or No- an, etc.)	14. Race - Am Black, Whi		
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and	ould be filed Mental Hygi arked other atic event, I	To Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame) Helen Selviell Doi								/
Maryland	2 should and Men ie marke		19a. Informant's Name/Relationship (Type, Print) Husang	19b. Mailing Addres	ss (Street and Numbe	or or Rural Re	oute Number, Cit	ty or Town, State,	Zip Code)	21/
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B	permit. Depertimport Import any inj		23a. Pagil Enter the disease, or com	L. Rus	1 20Sep	W. North	Ave,	Balto	Home, F	Approxima	ite
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	/Medical Examiner		resulting in death)	Due to (or as a consequent	•						
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.O. Box	that the death certifica ed by the attending phi detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 \(\text{Live birth} \) 2 \(\text{Feta} \) 4 \(\text{Pregnant at time of do } \) 9 \(\text{Unknown} \)	I death 3 ☐ Ectopic				23d. Date of de Month	livery Day	Year
<u>α</u>	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	cause given in Part I.			co use contribute		
Records,	w requires that s been signed E should be deta							1 Yes 24a. Was an	2 No 3 P	utopsy finding	Unknown s available
I Re	The ete h page	Completed						autopsy performed 1 Yes 2	death?	_	cause of
Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 1 npatient 2	ER/Outpatient 3 0	Other		Check only one	e 6 □Other (Sp	20.64)	
	g Physical dispersal di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		I. Describe how i		cny)	
Division of	or Attending after death. Director: After in by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	on 29a Place of Injury - At he	М	1 Tes 2		Location (Stree	t and Number or F	lural Route Nu	m <i>ber</i> ,
Ο̈́	\$ # 5 €	Cert	4 Homicide determined	building, etc. (Specif	ý)		d elega and	City or Town, S		e stated	
	ne Hoepital	edical	29a. Certifier (Check only 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examina and manner stated.	tion and/or investigation	on, in my opinion, dea	ith occurred	at the time, date	and place, and du	e to the cause	(s)
	To the within to the comple	M	29b. Signature and title of certifier	ul WN		9c. License number	-4	1 .	Date signed (Mor		
	1		30. Name and address of person who	completed cause of death (Item	n 23a) (Tvoe. Print)	F 106 1	T ME	ENA	armbee	12,20	006
	5		900 scator Ave	rue Britim	ore MD	21222	3 616	~ 1 4			
100	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture special	,					

			1 - For State Registrar	State of Maryland	/ Department of Health and Certificate of Death	Mental Hygier	Zulih Jhlihy
10 17 18	Physici /Medio	al	1. Decedent's Name (First, Middle, Las Rosa 4a. Facility Name (If not institution, give	Brundage	4b. City, Town, or Location of Dea	November	Day 2 Year 3: Time of Death 4: County of Death
	Examin Funeral Director	ier	Lorien Frankfi 5. Social Security Number 6. S	ord Nsg. & Reha	6. Baltimore	5. 8. Date of Birth	N/A
	e Maryland la-f ahow	ctor	10a. State 10b. County	10c. City, 1	altimore		10d. Inside City Limits 1 XYes 2 ☐ No
96	hours after death with the Maryland turel', or Iteme 23a or 28a-f ehow at Exportment outs be notified at	y Funeral Director	10e. Street and Number 1707 Gertru 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes - 2 No If Yes, Give	10f. Zip Code 2/2/6 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 1 Yes 2 No Specify:	Specify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: D
21215-0036	d within 72 jiene. r than "na	Completed by	3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		6a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired) HOUSEWIFE	orking	Kind of Business/Industry Domestic
Maryland	a la e	To Be	17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship ((Friend)	18. Mother's Na Eth 6 19b. Mailing Address (Street and Number or F	Ime (First, Middle, Maidle) Mae Mural Boute Number Cib	Price
	es 1 and 2 of Health ar If Item 27 is or other trau		MS. Bonne 20a. Method of Disposition 1 Burial 2 Cremation 3	COOK 20b. Plac	1707 Gertrude e of Disposition (Name of etery, crematory or other place)	St. Bal	Location - City or Town, State
Baltimore,	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer		22. Name and Address of Facility JOSEPH L. RUSS 2222 W. North A	Funeral ve. Balt	Home P.A. Wid 2121b
	Physician /Medical		23a. Part 1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. one cause on each line. a	Do not enter the mode of dying, such as cardia and Cell dung.	ac or respiratory arrest,	Approximate Interval Between Onset and Death
× 092	Examine executed spicion and purial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequer c. Due to (or as a consequer d.	ice of):		
.O. Box 68	death certifica e attending ph d for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 12 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	ath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
S, D	en signed by	Ď	Part II. Other significant conditions of	ontnbuting to death but not resulti	ng in the underlying cause given in Part I.		ouse contribute to the cause of death? 2 No 3 Probably
Il Record	has be	Completed				24a. Was an autopsy performed?	
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	Othor	eath (Check only one)	
Division of Vital	ing Phys Atter this uneral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Noutpatient 3 DOA Careful Warsing Bb. Time of Injury Mark? M 28c. Injury at Work? 1 Yes 2 No	Home 5 Residence 28d. Describe how in	
Divis	F 6 F C	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	Hospital 24 hours a Funeral I	edicai	29a. Certifier (Check only one) Certifying Ph 2 ☐ Medical Exam	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place a and/or investigation, in my opinion, death occ	e, and due to the cause curred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Med	29b. Signature and title of certifier	and mainer stated.	29c. License number		Date signed (Month, Day, Year)
	⊢ š ⊢ ŏ		Man and		057727	- 11	13/06
	2		30. Name and address of person who	completed cause of death (Item 23	3a) (Type, Print)	D1 0	13/06 MD 21239
	Sta Regista		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	Sperke	n bwa.	10111 123

06-08338	
Michael Bover	

Please Type or Print in Black Indelible Ink

chael Boyer		State of Maryland / I -For State Registrar	Department of <i>Certificate of</i>			Reg. No. 200	36070					
Physician/ edical Examine		1. Decedent's Name (First, Middle,Last) Michael Boyer			2. Date of Dea Month November	ath Day Year er 3, 2006	3. Time of Death 1300 hrs					
~~ <		4a. Facility Name (if not institution, give street and number) 3706 Parkside Drive		4b. City, Town, or Location of Baltimore		4c. County of Death						
Funeral			In yrs. last birthday)	If Under 1 Year If Under		N/A irth(MM/DD/YYYY) 9 Birt						
Director		135-62-2836 1XM 2 F 32 Yrs Months Days Hours Min. AUG 14,1974 Foreign AUG										
, any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										
ne Maryland or 28a-f show any <u>fred at once.</u>	흲	NJ Salem S	Salem	10f. Zip Code	 1	10g Citizen of What Cour	1 Yes 2 No					
3a or 28	Director	124 York St		08079		USA						
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	uneral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2		is Decedent of Hispanic Ori es, specify Cuban, Mexican		o- 14. Race - Ameri White, etc.	can Indian, Black,					
s after darral", or	by Fu	Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 X No specify		Specify: Whi	te					
5 72 hour in "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/I										
b-003. Id within ygiene. other than the ne Medi	Somp	12 Framer Construct 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)										
1215 d be file fental H narked o event, th	o Be (William H. Boyer 19a. Informant's Name/Relationship (Type, Print)	19h Mailine	Fra GAddress (Street and Nur	ncisk Bar		Zin Code)					
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene anti of Health and Mental Hygiene and: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	F	Angela M. Sweeney/Sist	er 102	Chestnut S	t Salem,	NJ 08079						
Ore, ges l and tof Heal		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	crematory or ot	•	Date	20c. Location - City or						
Baltimore, permit Pages l ar Department of Her Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee C. Todo	Laurel L	awn Name and Address of Facilit ayton Fune	11/14 <u>/06</u> ral Home	Bridgeto	n, NJ					
മ ഉട്ടി Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear? pproxima e Interv										
/Medical		failure List only one cause on each line. Immediate Cause (Final disease a Heroin into	oxication and				Between Onset and Death					
_/		or condition resulting in death) Due to (or as a consequentially list conditions,	uence of).									
	Examiner	if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated										
ecuted and transit												
Records, P.O. Box 68760, The law requires that the death certificate be executed care has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Physician/Medical			E,g861,11/16/06	TI	Loo I D						
30x 6876 death certificate e attending phy	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 Live birth	2 Fe		ic pregnancy	23d. Date of deliver	/ Day Year					
Box e death c the atten ed for us	hysic	1 Yes 2 No 9 Unknown 9 Unknown	me or death 5 0	ther (Specify)								
ires that the signed by I be detach	þ	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in P		tobacco use contribute to es 2 No 3 Prol	the cause of death?					
rds, v require s been sig	Completed				24a. Wa.		itopsy findings available completion of cause of					
tal Records, ciam: The law require certificate has been si ector, page 2 should b	Comp				1 🗸 Yes	formed? death? 2 No 1 ✓ Yo	es 2 No					
Vital hysician: this certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatien	t 2 ER/Outpatien	Othor	(Check only one) Nursing Home 5	Residence 6 🗸 Othe	r: Scene					
Division of Vital ral or Attending Physician: rs after death al Director: After this certiled in by the funeral director	on: T	27. Manner of Death 28a. Date of Injury (Month, Day, Yes	I	1 Van 2	No .	e how injury occurred	·					
ViSio or Atten fter deat birectori in by the	Certification:	2 Accident Investigation FTIQ 11/3/2		30 pm X et, factory, office building, e	etc 28f Location	(Street and Number or Ru	ral Route Number, City					
Division of Vital F the Hospital or Attending Physiciau: thin 24 hours after death the Funeral Director; After this certifinal papterly filled in by the funeral director.		4 Homicide determined (Specify) 29a. Certifier A Contifuer Physician To the best of my	House death accur	arred at the time, date and n		State 3706 Park						
Divisior To the Hospital or Attence within 24 hours after death To the Funeral Director;	Medical	(Check only one) 2 Medical Examiner: On the basis of exam and manner stated	ination and/or investiga	ation, in my opinion, death o	ccurred at the time, dat	te and place, and due to the	ie cause(s)					
	Š	29b. Signature and title of certifier		29c. License numbe O.C.M.E.	r	November 4, 20						
		30 Name and address of person who completed cause of de		Ot 1 B 111	24204							
	tate	Ana Rubio MD. Assistant Medical Exami 31. Date filed (Month, Day, Year) 22. Registrar:		Street, Baltimore, MD	21201							
Regis		NOV 1 5 2006	15 Ayou	<u> </u>								

DHMH 17 Rev 1/2001 OCME 2006

		1 - State Amend #2 Per	State of Marylar PHY g861 11/	nd / Depa 17/06 e	artment of F	lealth and N Death	ntal Hyg	giene leg. No.	006	36071	
		1. Decedent's Name (First, Middle, Last,)				Nowembe	th Day	Year	3. Time of Death	
Physici /Medio	_	Angeline Buczk	owski				Octobe	er 9,	2006	11:30Am	
Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. Co	unty of Death	1	
		2426 E. Baltim 5. Social Security Number 6. Sec	ore Street	last hirthday)	Balt If Under 1 Year	imore If Under 24 Hrs.	8. Date of Birth	$\frac{1}{n}$		nplace (State or Foreign	
Funeral Director			м 252F 90	Yrs.	Months Days	Hours Min.	(Month, Day		Col	untry)	
D		Usual Residence of Decedent					<u> </u>	910	bal	timore, MI	
nylan show	_	10a. State 10b. County		ty, Town or Lo						10d. Inside City Limits 1	
80-f	Director	MD n/a	Ba	altimo				10- Civi	-411111-1-0		
with th		10e. Street and Number 2426 E. Baltim	oro St		10f. Zip Code 2122	Λ		USA	of What Cou	untry ?	
18 234	eral	11. Marital Status	12. Was Decedent Ever in U	I.S. 13.		lispanic Origin? (Sp	pecify Yes or No-		Race - Amer	ncan Indian,	
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mentel Hyglene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f ehow importent: if item 27 is marked other than "natural", or items 23a or 28e-f ehow apply injury or other traumatic event, it a Modical Examiliar must be incitified at once.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 Yes 2 XNo	Specify:	Rican, etc.)		Black, White ecify: Wh		
2 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occup	eation during most of work	kina	16b. Kind	of Business/I	ndustry	
thin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	ung				
ygien ygien it, fr	Son	10 th 17. Father's Name (First, Middle, Last)		Shor	t order		o (Final Middle		taura	int	
De fil d off	Be					18. Mother's Nam					
hould d Mer mark maric	ဥ	August Savares 19a. Informant's Name/Relationship (7)		19b Maili	na Address (Street	Cather and Number or Rui	rine Bu			in Code)	
d2sith and traum		Virginia Eding				st Ave.		-			
Heel Heel tem 2		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other place		Date		ion - City or		
it. Pages rtment of rtent: if i njury or o		1 ⊠Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	Ho.	ly Ros	sary	11/1	3/2006			<u> </u>	
Depe impo eny i		Mlana 9 200		2	63 5 0	ss of Facility Jo	sepn N	. Zar əltin	nnino	Jr. FH MD 21224	
		23a. Part1. Enter the disease of comp shock, or heart failure. List only o			ter the mode of dyir	ng, such as cardiac	or respiratory ar		iore,	Approximate Interval Between Onset and Death	
Physician /Medical Examiner		disease or condition resulting in death)	a. Metastati Due to (or as a conse	quence of):	Blon Co	vicino	ma			Zyears	
uted	Examiner	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	Due to (or as a consequence of):							
death certificate be executed e ettending physicien end of for use as the burial-transit	dicai Exa	resulting in death) Last Due to (or as a consequence of):									
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es thet gned b be deta	by Ph	Part II. Other significant conditions co	entributing to death but not re	sulting in the u	ınderlying cause gr	ven in Part I.		obacco use		the cause of death?	
w requires been si should i	Completed						24a. Was			topsy findings available	
The law sete has page 2	E							rmed?	death?	completion of cause of	
	BeC	25. Was case referred to medical									
Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ØNo	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatie	nt 3□ DOA Ott	ner: 4 🗌 Nursing H	ome 5 Resid	dence 6	Other (Spec	cify)	
Jing After fune		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ry at rk? Yes 2 □ No	28d. Describe t	now injury o	ccurred		
or Al	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At a building, etc. (Spec	nome, farm, st rify)	reet, factory, office		28f. Location (S City or Tox		lumber or Ru	iral Route Number,	
To the Hospitel or At within 24 hours effer or To the Funerel Direct completely filled in by	edicai (29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the best of my kniner: On the basis of examinand manner stated.	nowledge, deal nation and/or in	th occurred at the finvestigation, in my	me, date and place opinion, death occu	rred at the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)	
To th withir To th comp	×	29b. Signature and title of certifier	0 0 0		29c. Licens			29d. Date s	igned (Monti	h, Day, Year)	
10		Clibriles (od	Lectus)		- '	546		NO	110	2006	
3		30. Name and address of person who	Heled cause of death (Ite	m 23a) (Type	Print) Raven ?	Bud Bul	timore	wo.	2123	9	
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	berke						
Regist	rar	NOV 1 5 2	006	Jes. Va	The state of the s						

		4	For State	St	tate of	Marylan		artment of H rtificate of L				Z 11115	360	72	
	Registrar 1. Decedent's Name (First, Middle, Last)						lilicate of t	Jeani	Reg. No.		3. Time of De				
	Physicia			1	RAVOR	12. 200C		AM							
	/Medic		JUNE 4a. Facility Name (If not institution	n, give stree	et and numi	ber),		4b. City, Town, or	Location of Death	NOVEM		County of Deat			
	Examin	er	THE Johns Ho	ale .	HOSE	ital		BAHIMO	13						
	Funeral		5. Social Security Number	6. Sex		. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v, Year)	9. Birti Co	hplace (State or F untry)	oreign	
	Director		578-22-7304	1 🗆 M	21 X 1F	83	Yrs.	Inomia Dayo		Mar. 6,	192		rginia		
	and w	-	Usual Residence of Decedent 10a. State 10b. County	/		10c. Cit	y, Town or Lo	cation					10d. Inside City I	Limits	
	Manyl:	ō	MD Ho	ward		La	urel						1 □ Yes 2	XNo	
	the 28a-	rec	10e. Street and Number					10f. Zip Code			10g. Citiz	zen of What Co	untry?		
	after death with the Maryland or items 23a or 28a-f show miner must be notified at	Funeral Director	7933 Hammond	Parkwa	y			20	0723			USA			
	deat	ner	11. Marital Status	12. \		lent Ever in U.	S. 13.	Was Decedent of H	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.))-	14. Race - Ame Black, White			
9	after or ite		1 ☐ Never Married 2XXMa	rried 1	1 ☐ Yes 2 f Yes, Give	2 ⊠ No		1 □ Yes 2 No	Specify:			Specify: Wh			
3-003e	ural",	d by	3 ☐ Widowed 4 ☐ Divorce	nt's Education	Year or Dat	tes:	16a Daca	dent's Usual Occup	ation			nd of Business/		-	
<u></u>	in 72	Completed	(Specify only high	est grade coi	mpleted)	4	(Give	kind of work done of DO NOT use retired	ne during most of working				,		
7	i with	E	Elementary/Secondary (0-12) 12th		College (1-	40r 5+)	Cler	·k			Tel	ephone	Co.		
and	e filed al Hyg othe vent,	BeC	17. Father's Name (First, Middle	, Last)					18. Mother's Nam	ne (First, Middle	, Maiden	Surname)			
Jai	Ments Ments arked atic e	2	William Bowm						Lott		rzer				
Mar	2 sho		19a. Informant's Name/Relation				1	ng Address (Street					Zip Code)		
e S	1 and tealth sm 27 ther t		Don E. Baker/	Husban	ıd	20b. F		Hammond I	Parkway,	Laurel,		20723 cation - City or	Town, State		
و	nt of h		1 ☐ Burial 2 【Cremation		oval from S	tate	emetery, cre	matory or other place idel Crem	i	.6/2006		nton, M			
Baitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The mortant: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	4 ☐ Donation 5 ☐ Other (wes		2. Name and Addre		*		·			
n n	permil Depar Impor any Ir		1/mink	Mu de	1 de	~M0016	0 3	13 Talbot	tt Avenue	, Laure	1, M	D 2070	7		
	7808		21a. Parti. Enter the disease, of shock, or heart failure. Lis					ter the mode of dyir	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Betwe	en	
	Physician		Immediate Cause (Final disease or condition	it only one of	Tuti	478 A	Lain	HEMDE	and the second second				Onset and De	ath	
	/Medical		resulting in death)	a	Due to (c	or as a conseq	uence of):	The of	Tine				\$ 41.15		
	Examiner	L	Sequentially list conditions,	uanaa afir											
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8/PU	death certificate be executed e attending physician and d for use as the burial-transit	dical E		d											
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X Q R	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant			come pf pregna rth 2 □ Feta		⊒Ectopic pregnancy	у		2	23d. Date of del Month	livery Day Ye	ar	
O.	e dea the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown		4□Pregna 9□Unkno	ant at time of own	death 5	Other (specify)				Month	Day 10	ui	
7	hat th d by t	Phy	Part II. Other significant condi	tions contrib	utina to de	ath but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of dea	ath?	
Records,	The law requires that the de ate has been signed by the a bage 2 should be detached	l by	,		5		Ü			1 🗆	Yes 2[□ No 3□ Pi	robably 4 🗹 🗖 🗓	knowп	
Ö	v requ	etec								24a, Was	an	24b. Were au	utopsy findings av	ailable	
	The lav ate has page 2	Completed									ormed?/	death?	completion of cau	se of	
Vital		Be C	25. Was case referred to medic	al					26. Place of Dea		1 Yes 2 No 1 Yes 2 No				
	Physicl this cer al direct	To B	examiner? 1 □ Yes 2 ☑ No	Hosp	oital: 1 🗹 ſr	patient 2] ER/Outpatie	nt 3 DOA Oth	ner: 4 ☐ Nursing H	lome 5□Res	idence (6 □Other (Spe	cify)		
Division or	ng Ph fter th meral		27. Manner of Death 1 ☑Natural 5 ☐ Pend		28a. Date o (Monti	of Injury h, Day Year)	28b. Time of Injury	Wor		28d. Describe	how injur	ry occurred			
<u>S</u>	tendleath.	catio		tigation	20. Di				Yes 2 No	ORA Lanation	(04		umi Davita Mumba		
2	al or Attending P after death. I Director: After t d in by the funera	Certification:		mined 4	28e. Place buildir	of injury - At n ng, etc. <i>(Speci</i>	fy)	reet, factory, office		City or To	wn, State	e)	ural Route Numbe	<i>H</i> ,	
_	spital ours a neral		29a. Certifier 1 Certify	ing Physici	an: To the	best of my kno	owledge, dea	th occurred at the ti	me, date and place	, e, and due to the	e cause(s)) and manner as	s stated.		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 ☐ Medic one)	al Examiner	: On the ba		ation and/or i	nvestigation, in my	opinion, death occi	urred at the time	, date and	d place, and du	e to the cause(s)		
	To th within To th comp	Me	29b. Signature and title of certif	ier				29c. Licens	se number		29d. Dat	te signed (Moni	th, Day, Year)		
	/		Soul Un	1	mp			ROS	-000		MOVE	mber	13,7006		
	15		30. Name and address of person	n who comp	leted cause	e of death (Ite	m 23a) (Type	Print)	St. BAL	tiMORES.	n/	alla i	1 91701	7	
	- C+	ate	31. Date filed (Month, Day, Yea	17/14	32. R	egistrar's Sign	ature	WOIPE O	31. DAL	I MUKE,	IVIF1	24 1424	6163	/	
	Regist			2006	Ma	in D	- Paris								
			14/4 - 4		41										

			1 - For State Registrar	State of Ma	aryland	d / Depa <i>Cei</i>	artment of rtificate of	Health a	nd Mental H	ygiene () ()	6 36073
	Physici		1. Decedent's Name (First, Middle, La Elaine E	Battee					2. Date of D Month		3. Time of Death 320 P M
ī	/Medic Examin		4a. Facility Name (If not institution, gi				4b. City, Town,	or Location of		4c. County of	Death
			Howard County	General	Hosp	ital	Col	umbio	a	Hou	vard
I	Funeral Director		5. Social Security Number 6.		e (In yrs. la 82	st birthday) Yrs.	If Under 1 Yea Months Days		4 Hrs. 8. Date of 8 (Month C	irth 9. 2/1923 M I	Birthplace (State or Foreign Country)
	D .		Usuel Residence of Decedent 10a, State 10b, County		10c City	. Town or Lo	cation				10d. Inside City Limits
	ehov	5	MD Howard			icott					1 ☐ Yes 2 € No
	28e-1	Director	10e. Street and Number				10f. Zip Code			10g, Citizen of Wha	t Country?
	with Sa or		4009 Chatham Rd.				21042			United S	•
	deeth	Funeral	11. Marital Status	12. Was Decedent			Was Decedent of	Hispanic Origi	in? (Specify Yes or N		American Indian,
36	within 72 hours after deeth with the Maryland ene. then "natural", or iteme 23a or 28e-f ehow the Madical Examiner must be notillisd at	ğ	1 ☐ Never Married > Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No		1 Tes, specify Cu 1 □ Yes 2 No		Puerto Rican, etc.)	Specify: To	White, etc. Thite
ŏ	2 hou	ted	15. Decedent's E	ducation			dent's Usual Occu		of working	16b. Kind of Busin	
Maryland 21215-0036	within 7 iene. 'then "n	Completed	(Specify only highest gi	College (1-4or 5	5+)	Secre	kind of work don- DO NOT use retir etary	ed)	or working	Federal	Government
D N	Hyg other	BeC	17. Father's Name (First, Middle, Las	t)				18. Mother	's Name (First, Middi	e, Maiden Sumame)	
<u>a</u>	Jenta Jenta rked tic ev	To B	Henry G. Laut	erbach				Mario	n Schoef	field	
	iges 1 and 2 should be filed within 72 hours after deeth with the Marylan it of Health and Mental Hygiene if item 27 is marked other then "natural", or iteme 23a or 28e-f show or other treumatic event, the Madical Examinat must be notilised at		19a. Informant's Name/Relationship George C. Battee/							ber, City or Town, Sta ty, MD 21	
Baltimore,	permit. Pages 1 a Department of Hea Important: if Item any injury or othe		20a. Method of Disposition 1 Burial 2 Sremation 3 4 Donation 5 Other (Spec		Ce	metery, crer	sition (Name of matory or other pl ke Crema		Nov 12 nc. 2006	20c. Location - Cit Beltsvill	y or Town, State e, Maryland
Balti	Deportit. Deportmental		21. Signature of Funeral Service Lice	insee	า่ ปกเน				neral Alter res Drive		Maryland 21286-
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. A Cu Due to (or as	ne. te a conseque WM	Responce of)	inatory		eardiac or respiratory		Approximate Interval Between Onset and Death days
	ted nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as			endie	1.			4.
,	cate be executed physicien end the burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence (f)	Dile	417			May 5
8760,	ysicie	dical		d	hole	as	titis				day
9	tifica ng ph as th	Ped	15.55441.5			7,5					
О. Вох	Attending Physician: The law requires thet the death certific in deeth. •ctor: After this certificate has been signed by the attending p by the iuneral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death 3	Ectopic pregnan Other (specify)	су		23d. Date of Month	f delivery Day Year
Division of Vital Records, P.O.	puires thet n signed b ald be deta	d by Pr	Part II. Other significant conditions		,	ting in the u		iven in Part I.			te to the cause of death? Probably 4 Junknown
Reco	Physician: The law requir r this certificate has been si ral director, page 2 should	Completed by							per	opsy formed? prior deat	
ta	an: T tificat tor, pa	a	25. Was case referred to medical	g-100-				26 Place	1 ☐ Yes of Death (Check only		Yes 2□ No
<u>=</u>	ysici is cer direc	TO B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆 E	R/Outpatien	t 3 DOA	ther		sidence 6 Other (Specify)
0 00	nding Ph th. : After th s funeral	Itlon:	27. Manne 1 Death 1	28a. Date of Inju (Month, Da	ry y Yea <i>r)</i>	28b. Time of Injury	W		28d. Describe	how injury occurred	
Divis	To the Hospital or Attending Ph within 24 hours efter deeth. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not determined		ury - At hor c. (Specify)	me, farm, str	eet, factory, office			(Street and Number of own, State)	or Rural Route Number,
	To the Hospital or within 24 hours efter To the Funeref Direction completely filled in I	ledical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner sta	f examination	eledge, death on and/or in	occurred at the vestigation, in my	time, date and opinion, death	place, and due to the occurred at the time	cause(s) and manne , date and place, and	er as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and fittle of certifier					ise number		29d. Date signed (A	fonth, Day, Year)
			Dundra	w-mp			Pe	12893	2	Nov o	7 2006
	6		30. Name and address of person who Francis Chuichi	completed cause of d		23a) (Type,				Columbia	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 5 2	DD6 32. Aegistr	ar's Signati	Jre A			7		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Day 75 Year 2006 1. Decedent's Name (First, Middle, Last) Month BETKEY **Physician** HARLES November 2 158.M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (II not institution, give street and number)
Northwest Hospital Examiner Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (M3517.68./19334 Birthplace (State or Foreign MD Country) 5. Social Security Number 216-30-9477 6. Sex 7. Age (lg yrs. last birthday) **Funeral** 12M 2□ F Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. int: If Item 27 is marked other than "nature!, or Items 23a or 28e-f show 10d. Inside City Limits 10c. City, Town or Location Health and Mental Hygiene. Item 27 is marked other than "naturs!", or items 23s or 28s-f show other treumatic svent, it a Madical Examinar must be rutified at 10a. State 10b. County MD Parkville → Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 6801 Fairdel Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Dayes 2 □ No If Yes, Give 1 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 25 No Specify: White Baltimore, Maryland 21215-0036 1953-1955 Completed by 3 Widowed 4 Divorced 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Self Employed Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)
Charles Betkey 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Zuerer ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 6801 Fairdel Avenue Parkville, MD 21234 19a, Informant's Name/Relationship (Type, Print)
Theodora Joy Betkey/Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State N8v 14 20a. Method of Disposition Chesapeake Crematory Inc. 2006 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 5 permit. Page Department of Importent: If any injury or once. 21. Signature of Funeral Service Licensee 2 rematrical Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advanced Bronohos **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours effer death.
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 res 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Depatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 1 Natural 5 ☐ Pending М 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOV 979 2006 054288 Northwest Hospital Courts 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramahani I Rangenagen 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006

		1 - For State Registrar	State of Maryland	l / Depa	artme rtifica	nt of He te of D	ealth and l		Reg. N		
Physic /Medi		1. Decedent's Name (First, Middle, Last, Gwendolyn Mereste			T			2. Date of Month	0	9 2006	unknown M
Exami		4a. Facility Name (If not institution, give 9821 Brassie Way	street and number)			gomer	ocation of Deathy Villas	ge	1.	c. County of E Montgo	
Funeral Director		5. Social Security Number 6. Se none	7. Age (In yrs. la	st birthday) Yrs.		or 1 Year Days	Hours Min.	(Month,	Birth Day, Year 09-19		Birthplace (State or Foreig Country) arbados
Maryland i-f ehow	tor	Usual Residence of Decedent		Town or Lo		illag	e	W-7'-			10d. Inside City Limits
with the	i Direc	10e. Street and Number 9821 Brassie Way			10f. Z	ip Code				itizen of What	t Country?
iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If I tem 27 is marked other then "naturel", or Items 23a or 28s-1 show or other traumatic event, the Moulcal Examinat must be routlied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Dec If Yes, sp		panic Origin? (S , Mexican, Puerl Specify:	pecify Yes or o Rican, etc.		14. Race - A	American Indian, Vhite, etc. Dlack
within 72 hou ane ihen "nature ne Meutcal E	Completed	15. Decedent's Edi (Specify only highest grad	cation	(Give	kind of y DO NOT	ual Occupat rork done du use retired)	ion iring most of wo	rking		Kind of Busine	·
Mat years A FE 15-0000	To Be Co	17. Father's Name (First, Middle, Last) Cyril Dudley Barro	w	OHEL			18. Mother's Nar		ddle, Maide	n Sumame)	Lal
1 and 2 shorthealth and Niem 27 le ma		19a. Informant's Name/Relationship (7) Wendy Barrow/Daugh					nd Number or Au Vay Mont				
Daltillois, permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 3 4 Donation 5 Other (Specify)	Removal from State	ace of Dispo	osition (N matory or	ame of other place,)	Date 27, 20	20c. l	Location - City	or Town, State
permit. Pa Departmen Important any injury once.		21. Signature of Funeral Service Licens	2 na135 8	R	арр	and Address Funera	of Facility Si al &Crem	lver S	Syc93	-	Ave. 20910
Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	<i>incei</i>		ode of dying,	such as cardia	c or respirato	ry arrest,		Approximate Interval Between Onset and Death
te be executed ysician and e burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence)								
death certificel	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	d	death 3	□Ectopic	pregnancy specify)				23d. Date of Month	delivery Day Year
The law requires that the steep seed is signed by the page 2 should be detached.	þ	Part II. Other significant conditions co	ntributing to death but not resul	lting in the u	ınderlying	cause giver	n in Part I.				te to the cause of death? Probably 4 Unknow
The lar	Completed							a	Vas an autopsy performed?	prior	e autopsy findings availab to completion of cause of h? Yes 2 \(\sum \text{No} \)
Physician: The I	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatie	nt 3 🗆 I	Other	26. Place of De			6 □Other (Specify)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day Year)	28b. Time o Injury	М	L	at } es 2 ∐No			ury occurred	
Ital or Att		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,)				City or	Town, Sta	te)	r Rural Route Number,
Hospital 24 hours a Funeral E	edical	29a. Certifier 12 Certifying Phy (Check only one) 2 Medical Exem	sician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, dea on and/or in	th occurre ivestigati	nd at the time on, in my opi	nion, death occi	e, and due to urred at the ti	the cause(me, date a	s) and manne nd place, and	or as stated. due to the cause(s)
To the within 2. To the complet	Me	29b. Signature and title of certifier	Menn		2	9c. License DA33	number		29d. D	ate signed (N	donth, Day, Year)
2		30. Name and address of person who co	ompleted cause of death (Item M.D. 6420 Ro 32 Registre's Signate 5 2006	23a) (Type	Print)) r Si	inte 410	o Bet	esda	UDSO	817
St Regis	ate	31. Date filed (Month, Day, Year)	32. Registra s Signati	ure de	A	W.					

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AND THE 2c per Hiss. (363,1/2)/07, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10 Day Physician John Kenneth Brownley 2006 3:00 Рм /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 8-23-1920 9. Birthplace (State or Foreign 5. Social Security Numbe 219-05-0735 7. Age (In vrs. last birthday) **Funeral** 1 MM 2∏F Months Days Hours Min. Maryland 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 KNo Montgomery Silver Spring MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20906 3372 Gleneagles Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: WWII Specify: white Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer/Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Spear Brownley Sr. Alice Fenhagen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ruth M. Brownley/wife Gleneagles Dr. Silver Spring, MD 20906 3372 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 11-13-2006 | Beltsville, MD Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Silver Spring, MD Rapp Funeral & Cremation Svc933 Gist Ave20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Failure Exacer bation **Physician** angestive Heart /Medical Due (or as a consequence of): Anoxic Encephalopathy **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Me and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760; Kidney attending physician Inronic Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ director, page 2 should be 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 272 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred funeral 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Doo6 2520 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Maria D'Arbella 1500 Forest Glen Rd Silver Spring, MD 20910 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 200 5 Registrar

Please Type or Print in Black Indelible Ink Muhammed Rafique Chaudhary State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 12, 2006 Chaudhary 2101 hrs Medical Examiner Rafique Muhammad 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Parkville **Baltimore County** 7101 Darlington Dr. If Under 1 Year If Under 24Hrs 9. Birthplace (State or 5 Social Security Number 6. Sex Age (In yrs. last birthday) Date of Birth (MM/DD/YYYY) **Funeral** oreign Director Country) Pakistan 58 11 01 48 1 XM 216-59-4794 2 Usual Residence of Deceden IOc. City, Town or Location 10d Inside City Limits ii y 1 Yes 2 X No or 28a-f show Parkville items 23a or 28a-f shoust be notified at once. Baltimore death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21234 2 Borgia Ct. 這 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes 10 Asian Divorced If Yes, Give Year 1 Yes 2 X No specify. Widowed Specify "natural", ⋧ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nasts
injury or other transmite event, the Medical Essa Completed Elementary/Secondary (0-12) College (1-4 or 5+) Store Owner Convenience Store 12th grade na 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marian Din Be Shah Din 19a. Informant's Name/Relationship (Type, Print) ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Borgia Ct. Parkville, Md 21234 Farzana Chaudhary-Wife 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Randallstown, Md 11/14/06 King Memorial Park Donation 5 Other Specify: 21. Signature Funeral Service Licensee Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, rethe 23a Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Gunshot wounds of arm and chest Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last 1 and - trans. sician/Medical UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be Box 68760, 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Year Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part ! ğ م 1 Yes 2 No 3 Probably 4 V Unknown Records, Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate h ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? DOA Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene this 2 1 🗸 Yes ဥ No After 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Nov 12, 2006 Subject shot at work Natural 0000 hrs 1 ✓ Yes 2 No 5 Pending To the Funeral Director: completely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 7101 Darlington Dr., Parkville, Md. determined (Specify) Convenience Store 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day Year) O.C.M.E November 13, 2006 5 aleri e of death (Item 23a) 30 Name and address of person who con 3 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month, Day Year) 32. Registrar's Signature State 5 2006 W. S. J. F. Bread

Registra

State of Maryland / Department of Health and Mental Hygiene- $\mathbb U$

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Aletha Louise Clapper 11:30 A M 13 2006 November /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Worcester County Berlin Nursing Home Berlin 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplece (State or Foreign Country) 5. Social Security Number Days **Funeral** Hours 1□ M 2□ F Aug.16 1915 91 217-40-1396 Director Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. fnside City Limits 10a. State 10b. County or 28a-f show rthen "natural", or items 23a or 28a-f ehov the Medical Experiment wat be notified at 1 ☐ Yes 2 ☐ No Director Worcester Co. Berlin 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code U.S.A. 21811 6 Sassafras Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 11 Marital Status Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural" or hand injury or other transment. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: þ 3√□ Widowed 4 □ Divorced white Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 8 0Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Price Mary **Holland** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Ann Keys (Daughter) 6 Sassafras Lane, Berlin, Md. 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 11/17/2006 Baltimore, Md. 21. Signature of Fundat Service Licenses McCully-Polyniak runeral none
237 E. Patapsco Ave. Baltimore, Md. 21225

Approximate
Interval Between McCully-Polyniak Funeral Home P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death mmediate Cause (Finat disease or condition resulting in death) Teevs **Physician** 12 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🕱 No 4 Pregnant at time of death 5 Other (specify) the 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 ☐ Probably 4 ☐ Saknown 1 ☐ Yes 2 ☐ No Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 No 2 No 1 TYes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DDA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation hours after death uneral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) Signature and title of certific 29c. License number 29b. 28 Name and address of person who completed cause of death (Item 23a) (Type, Print) Uzlenzy Frenwett To bell Deiggy 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 5 2006 Registrar

1000		1 - State Registrar 1. Decedent's Name (First, Middle, La	st)		i iiii cate t	of Death	2. Date of De	ath Day	Year	3. Time of Death
hysici /Medi		Elzie L. Cooper,	Jr.				11		2006	9:35A
zamir		4a. Facility Name (If not institution, giv			4b. City, Tow	m, or Location of Dea	th	4c. (County of Dear	th
. 8	æ .	Heartland Health			Hy:	attsville ear If Under 24 Hr	s. B. Date of Bir		ince Ge	
ineral rector		5. Social Security Number 6. S	ex 7. Age (a XIM 2□F	n yrs. last birthday) 86 Yrs.		ays Hours Mir		y, Year)		thplace (State or Foreign buntry) bama
ector		418 14 3171 Usual Residence of Decedent					05 17	1720		
how	_	10a. State 10b. County		Oc. City, Town or Lo						10d. Inside City Limit
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a or z	D .	10e. Street and Number	TT.		101. ZIP CO	20012		rog. Oniz	USA	,,,,,,,
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E se T		19a. Informant's Name/Relationship (reet and Number or F Lace NW, W				
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ysicien and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	consequence of):						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Day 9 /Month 9,2006 **Physician** Vovember 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore 22 0 8. Date of Birth (Month, Day 7. Age (In yrs. last birthday)
Yrs. 9. Birthplace (State or Foreign Country) Social Security Number 6 Sax (Month, Day, Year) 25 Virginia). **Funeral** 1 ☐ M 2 🕱 F 230-22-0872 Usual Residence of Decedent Director 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
and if tem 27 is marked other than "natural", or Items 23a or 28a-f show and it if the 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, its Mudical Expranter man be notified at 1 Yes 2 □ No Completed by Funeral Director Ke 10g, Citizen of What Country? 10e. Street and Numbe 10f. Zip C 222 Tue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jarner arner ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health ar Important: If Item 27 Is sny Injury or other trau esville, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address | Facility

OSEPH L. RUSS FI

2222 W. North Ave. 21. Signature of Funeral Service License Home, P.A. Md. 21216 23a. Part Enter the obease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physicien and street street The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1≥Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case re re to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier LECertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
Susan T Henley M.D. 1190 W. Northern Phux #101, Baltimore 21210 32. Registrar's Signature march

			For State Registrer	te of Maryland /			of Health an of Death		rgiene Reg. N2 0 0 (36081
	Physicia		Decedent's Name (First, Middle, Last) Norman	Clapper			-	2. Date of De Month Nov 7,	Day Ye 2006	3. Time of Death 3:30 PMM
	/Medic	al	4a. Facility Name (If not institution, give street a			4b. City, To	own, or Location of D		4c. County of E	
	Examin	er	Southern Maryland H			Cli	nton		Prince	e George's
	Funeral		5. Social Security Number 6. Sex 185 30 3631	7. Age (In yrs. last I	birthday) Yrs.	If Under 1 Months I		Min. (Month, Da	ay, Year)	Birthplace (State or Foreign Country)
	Director		185 30 3631 127 21	70				July	14, 1936 F	A
	iryland show	_	10a. State 10b. County	10c. City, To		cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he Ma	ecto	Maryland Prince Georg	e's Cli	nton	10f, Zip C	ode		10g. Citizen of Wha	1 ☐ Yes 2 ☐ No XX
	3a or	io I	8611 Shannan Drive				20735		United S	States
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di.	ss 1 end 2 should of Heelth and Men I Item 27 is marke r other traumatic	- 1	Joan Wather Clapper () 20a, Method of Disposition				an Drive, of place)Nov 1	Clinton.	MD 20735 20c. Location - City	
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Baltimore,	permit. Pages 1 Depertment of H Important: if Ite any Injury or ot		21. Signature of Funeral Service Licensee	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	22	. Name and	Address of Facility_	ee Funeral		c 6633 01d
	207 2 9		23a. Part1. Enter the disease, or complications	that caused the death. D					inton, MD	20735 Approximate
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alF		e Cor	25. Was case in telled to medical	Υ	r		OC Pleas of	1 ☐ Yes Death (Check only	2 No 1	Yes 2□No
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n of	ding Ph h. After th funeral	on: T	27. Manner of Death 1 Natural 5 □ Pending	Date of Injury 28t (Month, Day Year)	b. Time o Injury		c. Injury at Work?		how injury occurred	
Division	tten deat stor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e	. Place of Injury - At home,	, larm, str	eet, factory.	1 ☐ Yes 2 ☐ No	28f. Location ((Street and Number o	r Rural Route Number,
Š		Cert	4 ☐ Homicide determined 209	building, etc. (Specify)				City or To	wn, State)	
	To the Hospital or I within 24 hours efter To the Funeral Direction Completely filled in b	Medical (29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: Or one) an	To the best of my knowled the basis of examination dimanner stated.	dge, deat and/or in	vestigation, in	the tale, data and on my opinion, death	plane, and due to the occurred at the time,	gause(s) and manne , date and place, and	due to the cause(s)
	To the H	Me	29b. Signature and title of certifier	. > 111		29c.	License number		29d. Date signed (M	fonth, Day, Year)
)	1		Mcharl	M.D All	endi	~ c	7740.	20	11/8/	2006
7	110	إشارا	30. Name and address of person who complete	d cause of death (Item 23	а) (Туре, ТЦС	Privit)	O Bran-	L Ave	Trull.	hill And sory
	Sta	ite	31. Date liled (Month, Day, Year)	32. Registrar's Signature		n 185 .	3.000	of the same	- Trapo	7
	Regist	ar	NUV 1 5 2006	July Marker Allo		Bale Suns				

			1 - For Stete Registrar	State of Maryland / Dep	partment of Health and Mertificate of Death		giene 006	36082
			1. Decedent's Name (First, Middle, Last)		2. Date of Dea	ath	3. Time of Death
	Physici		Horace E. C	armenter		Nov 6,	Day Year 2006	7:00 A M
)	/Medio Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Dea	
	E Admini		Southern Marylan	d Hospital	Clinton		Prince	George's
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt. (Month, Day		tholace (State or Foreign
	Director		578 22 2354 X]M 2□F 83 Yrs.	Months Days Hours Min.	Dec 28	, 1922 Was	hington DC
	9		Usual Residence of Decedent					
	how	_	10a. State 10b. County	10c. City, Town or I				10d. Inside City Limits
	Ma-1-e	양	Maryland Prince G	eorge Dist	rict Heights,			1 ☐ Yes 2/☐XNo
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	•
	23a		2005 Glendora D	rive	20747		United Sta	tes
	ae i	Ine	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	or lit	by Funeral	XX Never Married 2 Married	Yes 2□NoWWII	1 ☐ Yes 24 ☐ TNo Specify:		Carrie Af	rican
g	within 72 hours after deeth with the Maryland ane. than "naturel", or items 23e or 28e-f ehow ha Mazlical Examinar must be notified at	d D	3 Widowed 4 Divorced	Year or Dates:			A	merican
7	nat	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (Giv	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	ring	16b. Kind of Business	/Industry
12	withir ne. han	E	Elementary/Secondary (0-12)	College (1-4or 5+)	vator Operator		HEW	
2	lled v tygia her t		17. Father's Name (First, Middle, Last)	LIC		o (Eiret Middle	Maiden Sumame)	
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiane. Important: if Item 27 is marked other than "naturel, or Items 23a or 28a-f ehow any figury or other treumatic event, the Madical Examinat must be notified at once.	Be	Henry Carpenter			lizabeth	· ·	
Ž	J Men nark	٦ ۲		- Orient				T- 0-4-1
Z Z	h and 7 is r	1	19a. Informant's Name/Relationship (Ty Sharon A. Skinner		ling Address <i>(Street and Number or Rur</i> 5 Glendora Drive,]			
ຍົ	1 end 1ealt 1ealt 1ealt 1her 1		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·		THE RESERVE AND ADDRESS OF THE PARTY OF THE	20c. Location - City or	
Baltimore,	ges if of h		tXBurial 2 ☐ Cremation 3 ☐ F		position (Name of ematory or other place) Nov 14			
<u>=</u>	tment tant:		4 □ Donation 5 □ Other (Specify)		nd Veterans Cemeter	- /		, Maryland
39	Depar Impor Impor In In		21. Signature of Funeral Scott Lice	$M/\Omega IIII_{-}(V)$	22. Name and Address of FacilityLee			
	005 e d		40-11 NO 4		Alexandria Ferry Ro			20735
			23a. Part 1. Enter the disease, or comples shock, or heart failure. List only or	cations that caused the death. Do not en ne cause on each line.	nter the mode of dying, such as cardiac	or respiratory ari	rest,	Approximate Interval Between Onset and Death
<u>*</u>	Physician		Immediate Cause (Final disease or condition	GANGRENE	Of toot			Criser and Death
	/Medical Examiner		resulting in death)	Due to for as a consequence of):	ARTERIAL]	0,000	_	
	Examiner		Sequentially list conditions.	REMINERAL	ARTEKIA	1152115	E	
	ъ ;	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
	and tran:	am	Cause (Disease or injury that initiated events resulting in death) Last					
8760,	cate be executed physicien and the burial-transit	Û	Todaming in double, and	Due to (or as a consequence of):				
876	ate b	dicai		l				
မှ	leath certifica ettending ph ifor use as t	Mec	IF FEMALE:					
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?		☐Ectopic pregnancy		23d. Date of de Month	ivery Day Year
<u>.</u>	he de the hed f	sic	1 Yes 2 No	4 Pregnant at time of death 5 9 Unknown	Other (specify)		ino.	ou, rou
P.O.	thet the death cer ed by tha ettendin detached for use	Physician/Me				l oo- Dida		the same of death?
	8	٥	Part II. Other significant conditions cor END STA	THE KEND	urperlying cause given in Part I,		bacco use contribute to	10
o	w requir been si should I	ted	LNY 31	Ole Mount	V17V176	1 1 1	es 2 No 3 Pr	obably 40 Menkhown
ပ္ပ	e law r has be	Completed				24a. Was a		topsy findings available completion of cause of
<u> </u>	The ate h page	Š				perfolition 1 ☐ Yes		ĆΔ
Vital Records,	iclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	7.77 7.77	26. Place of Deat	h (Check only or	ne	
<u>~</u>	hysic lidire	٥	1 Tes 2 No	lospital: patient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	me 5□Reside	ence 6 Other (Spe	cify)
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (M nth, Day Year) Injury	of 28c. Injury at Work?	28d. Describe h	ow injury occurred	
<u>ত</u>	uttendir death. ctor: Al y the fu	atic	2 Accident investigation		M 1 Yes 2 No			
Division of	or Attendation of Attendation of Director:	₩	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, tarm, s building, etc. (Specify)	treet, factory, office	28f. Location (S. City or Town	treet and Number or Run, State)	ıral Route Number,
	Ital or A	Certification:	100					
	Moepital 24 hours Funeral etely filled	edical	29a. Certifier Certifying Phys	sicien: To the best of my knowledge, dea ner: On the basis of examination and/or in	th occurred at the time, date and place,	and due to the c	ause(s) and manner as	stated.
		ledi	one)	and manner stated.				
	To the within To the comple	Σ	29b. Signature and title of certifier	4.1	29c. License number	2	9d. Date signed (Mont	
•			P WW	/ I//y	1)53885		11/6/2	2006
1	1/		30. Name and address of person who co	mpleted cause of death (Item 236) (Type	LAY75 ROAD # 30	2 (2.225
(77		4.77.1 1. 3 1411	17	-1111 KD HD # 30	7 CUN	wn I My	6783
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	de			
	region	31	LATA T O	10,000				

		1 - For State Registrar	State of Maryland	-	nt of Health and M te of Death		2006	36083
Phys		Decedent's Name (First, Middle, Last) Stanley Raymond Cha	arles			2. Date of Death Month Novembe	r ^{Day} 7, 2006	3. Time of Death
	dical niner	4a. Facility Name (If not institution, give stre Harford Memorial Ho		4b. City	Town, or Location of Death Havre de	Grace	4c. County of Death Harford	
Funer Directe		5. Social Security Number 6. Sex 046−58−7370 1≅√	7. Age (In yrs. la 50	st birthday) If Under Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month Day 1 08/31/1	9. Birth 956 Trin	place (State or Foreign ntry) Idad
ylend	a	Usual Residence of Decedent 10a. State 10b. County		Town or Location				10d. Inside City Limits
the Mar 28a-f	Funeral Director	MD Cecil 10e. Street and Number	Pe	erryville	p Code	100	J. Citizen of What Cou	1 ☐ Yes 2 BatNo ntry?
p ny seth with the same same same same same same same sam	ral Di	700 Carter Ct.	Apt. B . Was Decedent Ever in U.S	12 W D	21903		rindad	een Indian
ier de	<u>۾</u>	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2520) 25200 Specify:	Rican, etc.)	Black, White	etc.
215-0036 215-0036 in "natural", or Manager Exercises	Completed	15. Decedent's Educat (Specify only highest grade of	ompleted)	16a. Decedent's Usi (Give kind of w life. DO NOT	ork done during most of working	ng 16	b. Kind of Business/Ir Iospitalit	ndustry Y
d 212 filed with Hygiene. other the		Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Chef	18. Mother's Name	(First, Middle, Ma	iden Sumame)	· · · · · · · · · · · · · · · · · · ·
Maryland Maryland of 2 should be file fith and Mental Hy 27 is marked oth	To Be	George Sammy			Estelle	Wilson		
VI (77/6) Ve, Mary of Health and M ltem 27 is mark other traumati		19a. Informant's Name/Relationship (Type, Jennifer Khan/Sister			s (Street and Number or Rura el Lane Bel A:			o Code)
Baltimore, semit. Pages 1 ar Deportment of Hemmon of Hemmon of Hemmon of Hemmon of Hemmon of Humy or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	coval from State	ace of Disposition (Na metery, crematory or esapeake C	other place)	NOV 9	c.Location - City or T Beltsville,	
Balti permit. Depertuil Importe	once.	21. Signature of Funeral Service Licensee	the Moly		ci ^{Addres} and a fünera Green Pastures			ryland
Physicia /Medic: Examine	al	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the death.	Do not enter the mo	de of dying, such as cardiac o	or respiratory arres	1,	Approximate Interval Between Onset and Death 6 hours
B760, Cate be executed by societ and the burial-transit	dical Examiner	Sequentially list conditions, many, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque					
1 OWB. Box 6 death certifi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of deal 9 Unknown	death 3 □Ectopic i		<u> </u>	23d. Date of deliv Month	ery Day Year
		Part II. Other significant conditions contrib	buting to death but not resul	ting in the underlying	cause given in Part I.		cco use contribute to t	
STANEY RAYM of Vital Records, P.O Physician: The law requires that the rhis cartificate has been signed by the ral director, page 2 should be detach.	Completed by					24a. Was an autopsy performe	d? prior to co	opsy findings available impletion of cause of
Vital Vital siclan:	Be	25. Was case referred to medical examiner?	pital:		26. Place of Death	(Check only one)	- F. XIII	
On of ing Physical discussions of the control of th	lon: To	27. Manner of Death 1 Natural 5 ☐ Pending	1 Minpatient 2 LE		28c. Injury at Work?	me 5 ☐ Residence 28d. Describe how		(y)
Division of To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	M ne, farm, street, facto	1 Yes 2 No	28f. Location (Stree City or Town, S	et and Number or Rurs State)	al Route Number,
Hospite 24 hours Funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examiner	ian: To the best of my know r: On the basis of examination and manner stated.	rledge, death occurred on and/or investigation	i at the time, date and place, a n, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as s and place, and due t	stated. the cause(s)
To the within ?	Me	29b. Signature and title of certifier			c. License number		. Date signed (Month,	
2		30. Name and address of persol who comp	pleted cause of death (Item	23a) (Type, Print)	0053568 01 South Unit	on Aven	venber 9,	2005
9	State	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		laure de Grac	e Mary	rand 21	078
	strar	NOV 1 5 2006	A Comment	Annak.	0			
Drivin I/ Nev	#2001			ORIGINAL				

		-	For State Registrar	ite of Maryland		tificate of			ene 9. No 2006	36084
5	Physicia	an	1. Decedent's Name (First, Middle, Last) Alison Renee	Costa				2. Date of Deat Month	Day Year	3. Time of Death OLO 1 A M
	/Medic Examin		4a. Facility Name (If not institution, give street			•	r Location of Death		4c. County of Dea	
			Interstate 70 West 6 5. Social Security Number 6. Sex	at 45 Mile 7. Age (In yrs. la	ast birthday)	Hagerst If Under 1 Year	OWN If Under 24 Hrs.	8. Date of Birth	Washing 9. Bir	thplace (State or Foreign
9.5	Funeral Director		159-70-0626 1□ M 2 Usual Residence of Decedent		Yrs.	Months Days	Hours Min.	Sept. 21	1, 1983 Per	nnsylvania
	yland sow		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Mar Ba-f sh otifled	ctor	MD Washington	Hag	erstow				0g. Citizen of What C	1 ☐ Yes 2 🛣 No
	with the	Funeral Director	10e. Street and Number 946 Monet Drive			10f. Zip Code 2174	0		U.S.A.	ountry :
	death	nera	11 Marital Status 12. W	as Decedent Ever in U.S med Forces?	S. 13. \	Vas Decedent of F f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 23a-f show other traumatic event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married 1 If If S Widowed 4 Divorced Ye	☐Yes 2☐No Yes, Give 本 ear or Dates:			Specify:		Specify: W	nite
21215-0036	72 hou "natura	Completed	15. Decedent's Education (Specify only highest grade com	oleted)	16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	nation during most of wor	rking	16b. Kind of Business	/Industry
121	within jiene. r than "the Mee	dwo	Elementary/Secondary (0-12)	ollege (1-4or 5+) 4		rity Off			Retail S	tore
	be filed value tal Hygie dother sevent, the	Be C	17. Father's Name (First, Middle, Last)					ne <i>(First, Middle, I</i> D. Mykut	Maiden Surname)	
Maryland	hould be to the Mental is marked or matic eve	မှ	Ronald E. Costa, MD 19a, Informant's Name/Relationship (Type, P.	int)	19b. Mailir	ng Address (Street			r, City or Town, State,	Zip Code)
Ma	is 1 and 2 sho of Health and Item 27 is ma other traum		Susan M. Hardesty -	Mother	5 W.	Linden	Drive, C	arlisle,	PA 17013	
Baltimore,	ges 1 a t of He If Item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov	al from State	emetery, crei	sition (Name of matory or other pla			20c. Location - City o	
Ħ	permit. Pages 1 Department of H Important: If Ite any injury or ot		4 □ Donation 5 □ Other (Specify) 21. Signatore of Funeral Service Licensee	0ak		Crematory 2. Name and Addre			State Co. eral Home	llege, PA
Ba	Depar Impo any Ir		Kam B 2	line	1	1824 Rei	sterstow	n Road, I	Reistersto	wn, MD 21136
	VEN.	-	23a. I art1. Enter the disease, or complication shock, or heart failure. List only one cal	ns that caused the death	. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		In mediate Cause (Final disease or condition resulting in death)	Du to (or as a consequ	ence of):	Sount for Accido	rice In	ouma		
	Examiner		0	loter Vehi		Accido	ut			
	sit / 'A' ed	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du to (or as consequ	ience of):	100				
ď.	execut in and ial-trar	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequ	ience of):					
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical								
	certific nding p	/Mec		yes, outcome pf pregna			-		23d. Date of de	elivery
Box	The law requires that the death certiate has been signed by the attending tage 2 should be detached for use a	Physician/M	in the past 12 months? 1□Yes 2□No	□Live birth 2□Fetal □Pregnant at time of do □Unknown		_Ectopic pregnand ☐ Other <i>(specify)</i> _	;y		Month	Day Year
P.0	ires that the de signed by the a I be detached i		Part II. Other significant conditions contribu	ting to death but not resu	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
or Vital Records,	quires in signe	ed by						1 □ Y	es No 3□I	Probably 4 □Unknown
eco	law requir as been si 2 should	Completed						24a. Was a	an 24b. Were a	autopsy findings available completion of cause of
al B	sician: The law certificate has b irector, page 2 s						00 81			s 2 No
Vit	/siclar s certif	To Be	25. Was case referred to medical examiner? Yes 2 ☐ No Hospi	al: 1 □ Inpatient	ER/Outpatie	nt 3 DOA Ot	hor:	ath <i>(Check only or</i> Home 5□ Resid	ne) ence 6 ⊟Other (Sp	ecify)
n or	ng Phy fter thi		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	a. Date of Injury (Month, Day Year)	28b. Time o Injury	l Wo		28d. Describe h	ow injury occurred	11-610
Division	Attending Physician: r death. ector: After this certifics by the funeral director, p	Certification:	Accident investigation 3 Suicide 6 Could not be	e. Place of njury - At ho	~ ∫ 2 . ∞ ome, farm, st		Yes 🎉 No	28f. Location (S	treet and Number or I	Rural Route Number,
Di∨	al or A s after al Direct	Sertif	4 ☐ Homicide determined	building etc. (Specification)	V) ,			Interstan	to W West	at 45 mile
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page.		29a. Certifier (Check only Medical Examiner:	n: To the best of my kno On the basis of examina	wledge, deat	th occurred at the to the total the	time, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and manner added	as stated. ue to the cause(s)
	o the vithin 2 or the complet	Medical	29b. Signature and of certifier	and manner stated.		29c. Licen	se number	- 2	29d. Date signed (Mo	nth, Day, Year)
	F > F 0		> SPO			00	256966		Nov 12,	2006
	10		30. Name and address of person who complete	ted cause of death (Item	23a) (Type	Print)	Intial.	1 400	+ Hartst	2006 Dun MO2174
4	Şt	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	0. 1	111111611	Siles	1 pages 12	to the second
1	Regis	-	NOV 1 5 2006	100000	H. A	rosk				
DI	HMH 17 Rev 1/	2001		×	OF	RIGINAL /	1			

		For State	State of Maryland		ent of He			ene g. N.2 0 0 (36085
		Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
Physic	ian		ırlile				Novembe:	r 8, 2006	
/Medi		Fannie I. Ca		4b.	City, Town, or	Location of Death	210 1 2112 2	4c. County of D	
Exami	ner				Fink	sburg		Carr	roll
		2545 Deer Park Roa 5. Social Security Number 6. Sex	7. Age (In yrs. Ia		Inder 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
Funeral Director			M 2 ∑ F 92	Yrs. Mor	nths Days	Hours Min.	(Month, Day, June 5,	1914	MD
7.5	1	Usual Residence of Decedent							
land ow		10a. State 10b. County	10c. City,	Town or Location	1				10d. Inside City Limits
Mary i eh	ō	MD Baltimon	re I	Reisters	town				1 ☐ Yes 2 X No
the 28s	Director	10e. Street and Number		10	f. Zip Code		10	g. Citizen of What	Country?
deeth with the Maryland me 23a or 28a-f ehow		200 Salamy Dwire			2113	6		USA	
Peeth	Funerai	300 Salony Drive	2. Was Decedent Ever in U.S	. 13. Was I	Decedent of His	spanic Origin? (Sp	ecity Yes or No-	14. Race - A	American Indian, Vhite, etc.
riter	듄	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No			n, Mexican, Puerto	riicari, otc.)	Specify:	vinto, oto.
d within 72 hours at giene. naturel, or the medical Exam.	5	3 ₩ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	101	es 2XINo	Specity:		Specify.	White
within 72 hours atter ene. then "naturel", or ite	Completed	15. Decedent's Educ	ation	16a. Decedent's	Usual Occupa	ition Jurina most of work	ina	16b. Kind of Busine	ess/Industry
7 uin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	OT use retired)	uring most of work			
d with	E	2.5, (2.1.2.)	2	Bookk	eeper				holson Co.
IIIQ X IX IS-0000 be filed within 72 hours atter deeth with the Marylan tal Hygiene. d other then "naturel", or iteme 23s or 28s-1 ehow event, tre Medical Examinat ment to notified at	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N	Maiden Surname)	
	To B	Richard Iglehart				Merab			
aryia should land Meni emarke		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Ad	ldress (Street a	and Number or Rur	al Route Number,	City or Town, Sta	te, Zip Code)
		Lin Hitchcock Gra	anddaughter	2545 De	er Park	Road, F	inksburg	, MD 210	48
ite, M Heelth Item 27 other tr		20a. Method of Disposition	Ce	ace of Disposition	(Name of y or other place		Date	20c. Location - City	y or Town, State
Peges nent of nent: If it ant: If it		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	dlawn Ce	meterv	11,	/13/06	Woodlawn	ı, Maryland
		21. Signature of Funeral Service License			me and Addres	s of Facility	11824	Reister	stown Road
Dall permit. Departr import eny Inj	10. 1	Stephon M	1. Lensin	Eli	ne Fune	eral Home			MD 21136
		23a. Part 1. Enter the disease, or complic	ations that caused the death						Approximate Interval Between
	١.	shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		0	a a a .	1.1	•	Onset and Death
Pnysician /Medical	_	disease or condition resulting in death)	Due to (or as a consequ	14121	neur	acci	nin		1 de
Examine			Due to (or an a consequ	1. 1	1	senha	dise	are	254
F	70	Sequentially list conditions,	Due to (or as a consequ	And the second second					
Day is	듣	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1. 1	10	in				92yu
and and	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequ	ience of):					
. Box 68760, death certificate be executed e attending physicien and id for use as the burial-transit	<u>電</u>								
phys the	dical	,							
BOX 6	Physician/Me	IF FEMALE: 23	3c. If yes, outcome of pregna	ncy				23d. Date o	f delivery
BOX sath cert attendin for use	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		opic pregnancy ner (specify)			Month	Day Year
the de ached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
	문	Part II. Other significant conditions con	tributing to death but not resu	ulting in the under	lying cause give	en in Part I.	23e. Did tol	bacco use contribu	ite to the cause of death?
S & &	þ						1 🗆 Y	es 2 3 10 3 [☐ Probably 4 ☐ Unknown
Vital Records, P sicien: The law requires tha certificete hes been signed the director, pege 2 should be det	Completed						240 14500	a 24b Wa	re autopsy findings available
Rec The law	ğ						24a. Was a autops perfori	sy prio	r to completion of cause of
The la	등	i							Yes 2□ No
of Vital F Physicien: Th ribis certificate ral director, peg	Be (25. Was case referred to medical examiner?			Ton.		th Check only on	16)	0 1
y sic	ုင	1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2	<u>_</u>	DOA Oth	4 Nursing n		ence 6 Other	
n of ng Phy Iter this neral d		27. Manner of Death 1 ☑Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe no	ow injury occurred	Lund
VISION Attending or death. ector: After by the fune	ati	2 Accident investigation				Yes 2 □ No	221 1 1 10		/
Division or Attending after death. Director: Afte	Iĕ	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		factory, office		City or Tow		or Rural Route Number,
Division of with the Hospital or Attending Physwithin 24 hours after death. To the Funaral Director: After this completely tilled in by the funeral director	Certification:								
Hospital Hospital Punaral i tely tilled	cai	29a. Certifier 1 Certifying Phys	sician: To the best of my kno ner: On the basis of examina	wiedge, death oct tion and/or invest	curred at the tir igation, in my o	me, date and place opinion, death occu	red at the time, o	ause(s) and mann late and place, and	er as stated. I due to the cause(s)
he H in 24 he F plete	ledicai	one)	and manner stated.					29d. Date signer (
To the within 2 To the comple	Σ	29b. Signature and title of certifier	. 1 1		29c. Licens	or Humber		July Signed ()	
,		John My	Whaten the		DZ	5947	}	1119/2	-004
4		30. Name and address of pelson who co	empleted cause of death (Item	n 23a) (Type, Prin	t) /	200	1.	1	7
り		John W. Mid	duten MD	1886	ock	<d n<="" td=""><td>4mm s</td><td>ter Mi</td><td>1415/</td></d>	4mm s	ter Mi	1415/
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	200 L	, •		•	
Regi	strar	\$671/1 5 200	S 1 167	LO A	AD =				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For	artment of Health and M	entai mygien Reg. N		36086
T	Physicia		1. Decedent's Name (First, Middle, Last)		Date of Death Month	ay Year	3. Time of Death
À	/Medic	al	Voris C. Clark	4b. Cit. Town or booting of Dooth		10, 2006 lc. County of Death	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Jarrettsville	4	Harfo	
	Farmer		Madonna Heritage 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs	8. Date of Birth	Q Rieth	nplace (State or Foreign
	Funeral Director		185-28-3888	Months Days Hours Min.	Month, Day, Year	30 Pe	nnsylvania
	yland low at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	a-f sh	ctor	Maryland Baltimore Towso	n			1 ☐ Yes 2 💢 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. 0	Citizen of What Co	untry?
	ath w	la	1612 Dogwood Hill Road	21286	eite Van er No	U.S.A.	ican Indian
	ter de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Merce 2 □ No 1057	Was Decedent of Hispanic Origin? (Spe If Yes, specity Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
336	urs af al", or Exami	þ	1 □ Never Married 2 □ X Married 1 □ X Yes 2 □ No If Yes, Give 1 953 - 1957 Year or Dates.	1 ☐ Yes 2 No Specify:		Specify: Wh	ite
2-0	72 hours after death with the Maryland natural"; or Items 23a or 28a-f show iteal Examiner must be notified at	ted	(Specify only highest grade completed) (Give	dent's Usual Occupation	16b.	Kind of Business/I	ndustry
21215-0036	within iene. than "i	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	T. T. T. T. T.	ncuranco	Company
2	filed w Hygie ther t		17. Father's Name (First, Middle, Last)	President & Chief A	(First, Middle, Maid		Company
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be	Ralph Clark	Cora	a Reed		
ary	2 should be and Menta is marked aumatic ev	F-		ng Address (Street and Number or Rura	l Route Number, City	y or Town, State, Z	(ip Code)
	1 and 2 Health a em 27 is			Dogwood Hill Road		Maryland	
ore	of He		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition Cemetery, cre	osition (Name of D matory or other place)	ate 20c.	Location - City or	Town, State
Ě	ment of I tant: If Ita		4☐Donation 5☐Other (Specify) Moreland	Memorial Park 11-1			Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.				ck Towson owson, Mar		Home, Inc. 1204
	4		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death) a. 5eps://doi.org/10.1001/j.j.com/j.j				doys
	/Medical Examiner		Due to (or as a consequence of).				2 months
	•	- d	Sequentially list conditions, if any, leading to immediate could be that Underlying b. Due to (or as a consequence of):				7 (10/07/100
	d d	Examiner	that initiated events				marke
o,	e exectan an an arial-tr		resulting in death) Last Due to (or as a consequence of):			***	Years
68760,	ificate be executed groups and the purial-transites.	edical	d. Alzoheimers	Disease			Years
			IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of deli	ivery
Вох	The law requires that the death certifite has been signed by the attending tage 2 should be detached for use as	Physician/M	in the past 12 months? Use State □Ectopic pregnancy □ Other (specify)		Month	Day Year	
P.O.	that the de led by the a detached	hysi	9 ☐ Unknown				
	gned	by P	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.			the cause of death?
ord	w requires to been signer should be of	ted	CAD		1 Ll Yes	2 /∆ N0 3∐ Pr	obably 4 ☐Unknown
Sec	has be	Completed			24a. Was an autopsy performed	prior to o	topsy findings available completion of cause of
or Vital Records,				00 Pl (P (I	1⊡ Yes 2. 💢	No 1 ☐ Yes	2 □ No
Vit	Physician: r this certific ral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕷 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death	me 5 ☐ Residence	6 ∏Other /Sne	ciful
	G + 5	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of Manual Poly Control Poly Contr		28d. Describe how in		siry)
ion	Attending I or death. ector: After by the funer	atio	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No			
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St		ural Route Number,
	spital ours a neral i		29a. Certifier 1X Certifying Physician: To the best of my knowledge, dea				
	he Ho in 24 h he Fui pletely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or i and manner stated.				
	Vithi To t	Σ	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Mont	h, Day, Year)
			Wind May in	D31391	Nov	ember 10	, 2006
	1211		30. Name and address of person who completed cause of death (Item 23a) (Type		2 Back	md a	1206
Į.	Sta	ate	31. Date filed (Month, Day, Year). 32. Registrar's Signature				
	Regist		NOV 1 5 2006	nexts.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Chen JOXPH O L /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Oak Crest Care Center Parkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Dec. 14, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1√2 M 2 □ F 091-26-5639 85 Yrs China Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or Items 23a or 28a-f show the Mudical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo MD Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8800 Walther Blvd. 21234 USA #1205 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced Chinese Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Self Employed Restaurant permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygle. Important: If item 27 is marked other the eny injury or other treumatic event. Ite once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) York Chen Lei Yee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) step daughter 615 Wilton Road; Baltimore, MD 21286 Vivia Chang 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 11/14/06 Towson, MD \$ ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Jun 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician DNIMMENIO /Medical Due to (or as a consequence of): Examiner debili Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Cher (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 → No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending investigation 1 Yes 2 No death. 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. Livense number 29d. Date signed (Month, Day, Year) 111001

State Registrar

31. Date filed (Month, Day, Year) ~

32. Registrar's Signature 5 2006

who completed cause of death (hem 23a) (Ty Prior

Burrentund

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend item# 29d, perMD, g861, 11/15/@e##ficate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER DOS, 2006 **Physician** 2:40 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) **Examiner** Joseph Medical Center Saint 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1□M 2▼F 64 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10d, Inside City Limits 10c. City, Town or Location ns 23a or 28a-f show must be notifled at 1 Yes 2 □ No Dai Director + more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 rive ewood by Funeral filed within 72 hours after death ural", or items ? . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) condary (0-12) and Mental Hygiene. College (1-4or 5+) Housind nee traumatic event, Be Pages 1 and 2 should be ပ 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 2120+ Department of Health Important: If item 27 any Injury or other tr 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or 1 Burial 2 ☐ Cremation 3 Removal from State 5 Other (Specify) 4 Donation 21. Signature of Fundra Service bicensed MODIS 00 M 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death DAYS Immediate Cause (Final disease or condition resulting in death) DILATED AND HYPERTROPHIC CARDIOMYOPATHY **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death Division or Vital Records, P.O. been signed by the sahould be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CORONARY ARTERY DISEASE 1 ☐ Yes 2 □ No 3 Probably 4 Unknown Completed HISTORY OF CEREBRAL VASCULAR ACCIDENTS 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has to autopsy performed certificate 2□No END STAGE RENAL DISEASE Yes 2 No 'es or Attending Physician: 25. Was case referred to medical examiner? funeral director Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 ☐ Yes 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 2 Accident (Month, Day Year) Iniury s after deau... ral Director: Aftr 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a completely filled the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0060495 11/10/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21204 DRIVE TOWSON. 7601 OSLER FAN M 31. Date filed (Month, Day, Year) 32/Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

06-08550 Preston Dolly •

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

reston Dolly		1- For State	iano / Departime 				2006	3608
Physici		1. Decedent's Name (First, Middle,Last)				Reg. I		3. Time of Death
ledical Exam		Lrepron	lilliam		lly	November 9,		1724 hrs
		4a. Facility Name (if not institution, give street and Good Samaritan Hospital	number)	4b. City, Town, or Baltimore	Location of Death		4c. County of Death	
Funeral		Social Security Number 6. Sex	7. Age (In yrs last birth		ar If Under 24Hrs.	8 Date of Birth/N	MM/DD/YYYY) 9 Birl	hplace (State or
Funeral Director		226-64-3552 1XM 2F		Yrs. Months Day	e Hours Min	02 09	Foreig	
		Usual Residence of Decedent	37	115.		02 03	40	, VA
any		10a. State 10b. County	10c. City, Town of	or Location				10d Inside City Limits
Maryland 28a-f show d at once.	ō	MD NA	Balt	imore				1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cour	ntry?
ith the 1 23a or notifie		509 Radnor Ave	ecedent Ever in U.S.	13. Was Decedent of Hi	21212	cify Ves or No-	U.S.A.	can Indian Riack
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygens 7's marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	uneral	1 Never Married 2 X Married Armed	Forces?	If Yes, specify Cuba			White, etc.	carringian, black,
ifter de il", or	by Fι	3 Widowed 4 Divorced If Yes, Give Y		1 Yes 2 X No	specify:		Specify: B.	lack
5-0036 led within 72 hours after Hygiene other than "natural", the Medical Examiner	q pa	15. Decedent's Education (Specify only highest gr		Decedent's Usual Occupa			6b. Kind of Business/I	ndustry
36 n 72 h nan "r ical E	plete	, , , ,	(1-4 or 5+)	3			D	•
-000 f withing giene ther the	Complet	12th grade 25	rs	Master Car	rpenter 18.Mother's Name (I	First, Middle, Maid	Home Re	epair
21215-0036 und be filed within 7 Mental Hygiene marked other than e event, the Medical	Вес	Richard Dolly Sr.			Martha	Anne Sn	nith	
21 hould b d Men s mar	일	19a. Informant's Name/Relationship (Type, Print)	19b	. Mailing Address (Stree	et and Number or Ru	ral Route Number	r, City or Town, State	Zip Code)
MD 1d 2 sho lith and m 27 is aumati		Annie R. Dolly-Wife		09 Radnor				1212
ore, es lar of Hea If iter		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal	from State cremato	f Disposition (Name of ce bry or other place)	- '	- 1	Oc. Location - City or	
Baltimore, MD 21215-005 permit. Pages I and 2 should be filed within Department of Health and Mental Hygene Important: If ifeen 27 is marked other It injury or other traumatic event, the Med		4 Donation 5 Other Specify	Metro	Cremator		/18/06	Baltimo	re, Md
Balti permit. Departn Import		21. Signature of Funeral Service Licensee	D.	22. Name and Addres March F/				
Physician		23a. Part I. Enter the disease, or complications that	caused the death. Do not	14300 Waba t enter the mode of dying	such as cardiac or r	espiratory arrest,	nore, Md shock, or heart	21215 Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Acute	coronary artery	thrombus due	to planue r	unture		Between Onset and Death
xaminer			a consequence of):					
	e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as	a consequence of):					
_	min	cause. Enter Underlying Cause						
red	Exa	events resulting in death) Last Due to (or as d.	a consequence of):					
760, icate be executed physician and the burial - transit	ical	X UNPENDED X AMENDED) #2 22- 27 20-	ME CO	1/16/07	TTI		
'60, ate be	Medical		#2,231,27,200 s, outcome of pregnancy	a-f, perME, G&	03, 1/10/0/		23d. Date of delivery	L
687 certific nding p	sician/	past 12 months?	birth 2 gnant at time of death	Fetal death 3	Ectopic pregnant	СУ	Month D	ay Year
Box 687 Re death certific The attending p	hysic	1 Von 2 No 9 Hokoowo	nown	Other (Specify)				
P.O. E	Δ.	Part II. Other significant conditions contributing	to death but not resulting	in the underlying cause	given in Part I.	23e. Did tobac	cco use contribute to 1	he cause of death?
ires that signed by the deta	d by						2 No 3 Prob	ably 4 🗸 Unknown
cords, law requi has been 2 should	plete					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
Recorder The lacate his page 2	Completed					performed 1 Yes 2	d? death? No 1 ✓ Ye	s 2 No
Vital Rec nysician: The l this certificate l	Be	25. Was case referred to medical examiner?			of Death (Check or Other; Nursing			
Division of Vital Records, tat or Attending Physician: The law requint as the class as the class has been stall bircour. After this certificate has been stood in by the funeral director, page 2 should I	욘	1 ✓ Yes 2 No	Inpatient 2 ✓ ER/Outle of Injury 28b. T	·		Home 5 Res	sidence 6 Other	
on of \nding Phyth	ion:	1 Natural 5 Rending (Mon	nth, Day, Year)	1 🗔	Yes 2 No	subject su	stained an a	cute cardiac
rision r Attence er death irector:	ficat	2 21 Accident investigation 28e. Pl	11/9/2006 $4:24$ ace of Injury - At home, far		building, etc. 2	8f. Location (Stree	ng apartment et and Number or Rui	al Route Number, City
DIVI Spital or cours afte neral Direction	Certification:	Suicide 6 Could not be determined (Specif	other-scene		B) 6018 Marjo MD	rie Lane
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate the Funeral after death completely filled in by the funeral director, page 2 should be detached for use as the		29a, Certifier (Check only 1 Certifying Physician: To the b						
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner:On the basi and manner	s of examination and/or in stated					
	Σ	29b. Signature and title of certifier	D	29c. Licens	M.E.	1	od. Date signed <i>(Mor.</i> November 10, 20	
		30. Name and address of person who completed ca	use of death (Hom 22c)					
-		Zabiullah Ali, M.D. Assistant Med		1 Penn Street, Ball	timore, MD 2120	01		
S	tate	31. Date filed Worth, Day, Year) 2006	Registrar's Signature	1211				
Regis	trar	MONT 9 TARD	the St was	3542				

State of Maryland / Department of Health and Mental Hygien [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1:20 p **Physician** Nov 10, 2006 Estella C. Day /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville Mariner Health & Rehab - Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 C F Maryland May 4, 1922 217-14-9831 84 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 ehov any njury or other treumatic event, the Musical Exertines triust be nutitied at once. Baltimore 1 Yes 2 No Maryland N/A Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21229 3102 Leeds Street 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black Specify: Ā 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Self Employed College (1-4or 5+) Elementary/Secondary (0-12) Beautician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith Newman James Newman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3102 Leeds Street Baltimore, Maryland 21229 Diane E. Smith Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/15/06 Baltimore, Md. Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or helpst failure. List only one cause on each line. Approximate Interval Between Onset and Death enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** eumone /Medical resulting in death) Due to (or as a consequer Examiner Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed led by the ettending physicien and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Tilpknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed Records. 2 page 2 should be 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 202 No certificete 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital the Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours efter death. M 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar 31. Date filed (Monti

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November II, **Physician** 2006 DEWEY LEE DUVALL 5:45 a M /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 410 A. Brock Bridge Road Laurel Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1□M 2□F XX 213-38-1029 69 July 31, 1937 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c, City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2☐ No Director Maryland Anne Arundel Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 20724 410 A. Brock Bridge Road U.S.A. r than "natural", or Items 23a the Medical Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify. Specify: ģ White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 is marked other than "i Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Bus Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Dewey Duvall Nellie Hopkins ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Step Item 27 i Kathy Lynn-Hamrick Phillips/daughter 47 Wyegate Court Owings Mills, Maryland 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Important: If Iter
any Injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ivy Hill Cemetery 11/20/2006 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung Cancer (metastatic) 5 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical S attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death signed by the a d be detached f 2 No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2【X No 24a. Was an page 2 s perform 1☐ Yes 2 X X 0 Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5XX esidence 6 Other (Specify) 1 ☐ Yes 2 📉 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28b. Time of 28a Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? al or Attending P after death. I Director: After i d in by the funera Certification: After (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral C Errifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 0036371 November 14, 2006 30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print) 3169 Braverton Street, Suite 201, Edgewater, MD Raymond E. Banfer, MD 21037 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEALE) Registrar 2006

DHMH 17 Rev 1/2001

			For State Registrar	State of M	aryland /	Depa <i>Cen</i>	rtment	of H	ealth a Death	and M		giene	006	36092
		2,	Decedent's Name (First, Middle, Las	t)							2. Date of Dea	ath	.,	3. Time of Death
ш	Physici		Robert E. Emmo	ns Sr.							Novembe	er 10	2006	2:17 p ^M
	/Medic Examin		4a. Facility Name (If not institution, give		1		4b. City,	Town, or	Location of	of Death		7	ounty of Death	
	LAGITIII		901 Chesapeake D	r.			St	even	svil	le		Que	een An	nes
	Funeral		5. Social Security Number 6. Se	7. A	ge (In yrs. last b	irthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt	h v. Year)	9. Birtt	nplace (State or Foreign untry)
п	Director		213-34-0976	M 2□F	70	Yrs.	TVIGITO IS	Juys	110010		Aug. 4	, 193	6 Mar	yľánd
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Loc	ation							10d. Inside City Limits
	aho	5	Maryland Queen A	nnes	Steve									1 □ Yes 2 No
	the M	by Funeral Director	10e. Street and Number	inco	500.		10f. Zip	Code		-		10a. Citizer	n of What Co	untry?
	with	2					102	0020	21666	6			USA	
	ns 23	era	901 Chesakeake Dr	12. Was Decedent	Ever in U.S.	13. W	Vas Deced	ent of His			cify Yes or No- Rican, etc.)		Race - Ame	rican fndian,
"	r iten	표	1 ☐ Never Married 2 ☐ Married	Armed Forces' 1 ☐ Yes 2 🔀						, Puerto I	Rican, etc.)		Black, White	
ဗ္ဗ	al', o	ρ	3 MWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2	MO X	Specify:			Sp	pecify: W	hite
21215-0036	72 hours effer deeth with the Maryland natural', or items 23s or 28s-f show dical Exacting from the rodified at	Completed	15. Decedent's Ed (Specify only highest grad		16a	(Give k	ent's Usua	k done d	uring most	t of workii	na	16b. Kind	of Business/l	ndustry
2	ithin	npie	Elementary/Secondary (0-12)	College (1-4or	5+)		O NOT us							
7	ygier ygier tt,	ខ	12	0			Inspe			de Nome	(First, Middle,		inghou	se
Ē	be fill	Be	17. Father's Name (First, Middle, Last)									sgrov		
yla	ould 1 Mer narke	2	Clarence Emmo		10	b Mailine	Addross	/Stract o		ginia	I Route Numbe			in Cade)
Mai	12 st h and 7 is n traun					`		•						ip Code/
e,	1 end Heaft am 2 thar		Virginia C. Dugge 20a. Method of Disposition	r (Daugnte	20b. Place	of Dispos	ition (Nam	e of	1		ille, Mar		tion - City or	Town, State
5	ages nt of t: #f it		1 Burial 2 ☐ Cremation 3 ☐				atory or of	-	1	1/14/	2006	ProoleTs	m Dorde	Maryland
Baltimore, Maryland	permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s-f ahow any injury or other traumatic avant, the Medical Experiment must be notified at ADEs.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License	1	Cedar I			-	s of Facilit		2000	DIOOKI	/II raik,	Pat yland
Ba	Depermine Depermine trimpo any is		Har I	1 Sea	wh	Mc	Jully-	Polyn	iak Fu	neral	Home P.A dena, Mar	Tand	21122	
			23a. Part1. Enter the disease, or comp	lications that cause	d the death. Do								21122	Approximate
	Dhysisian		eflock, or heart failure. List only of		ING- (m	12-18							Interval Between Onset and Death
	Physician /Medical	-	disease or condition resulting in death)	a	a consequence									TUGH
	Examiner													
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):								
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o,	e exercien ar	EX	resulting in death) Last	Due to (or as	a consequence	of):								
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9	ing pl	Med	IF FEMALE:			_								
Вох	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal deat		Ectopic pre					23d	 Date of deli Month 	very Day Year
	the a	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnant a 9☐ Unknown	t time of death	5	Other (spe	ecify)						
P.0.	that the death certific ed by the attending p deteched for use as		Part II. Other significant conditions co	entributing to death	out not resulting	in the un-	derlying ca	ause give	n in Part I.	-	23e. Did to	bacco use	contribute to	the cause of death?
Vital Records,	w requires that s been signed I s should be det	d by									1/280	es 2□N	No 3□Pro	obably 4 Unknown
Š	law requires as been sign 2 should be	ete									24a. Was	an 2	Ah Were au	topsy findings available
Rec	@ ~ CV	Completed									autop	sy mede	prior to death?	completion of cause of
ā	n: Ti ficate or, pa	မ င်	25. Was case referred to medical						26 Plans	of Dooth	1 ☐ Yes (Check only o	2 No	1 ☐ Yes	20/No
₹	sicla s cert lirect	To B	evaminer?	Hospital: 1 ☐ Inpati	ent 2 ER/O	utnatient	3□ D0	Othe	r	rsing Hor			Other (Spec	n(v)
ō	Attanding Physician: r death. sctor: After this certification; life funeral director, life		27. Manner of Death	28a. Date of fnj (Month, Da	ury 28b.	Time of		Bc. Injury Work			8d. Describe h			,,
ö	ath. r: Aft	atio	1 PNatural 5 Pending 2 Accident investigation	(MOHIII, De	ly rear/	Injury	м		res 2 □ l	No				
Division	Attandi ar death. actor: A by the fu	ific	3 ☐ Suicide 6 ☐ Coufd not be 4 ☐ Homicide determined	286. Place of III	jury - At home, f	arm, stre	et, factory	, office		2	28f. Location (S City or Tow		lumber or Ru	ral Route Number,
Ö	rs efta al Dir	Certification:												
	To the Hospital or Attending Physician: The I within 24 hours eiter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		(Check only \ 2 Medical Examp	sician: To the besi	of examination a									
	tha h hin 24 tha f npiete	Medicai	one)	and manner s				. License					igned\/Monti	
	o vit	-	29b. Signature and title of cettiler	11/2 11	11		230	- Copilate	170	130	241	1 1	10/7/	176
,			2 my	MAN	N1)			N	LY			111	1010	
	V		3b. Name and address of person who o	Chibiered gante of	death (Item 23a)	Y Y	57	ME	RI	30	D AW	WAF	PUS!	MODACON
	Sta	te	31. Date filed (Month, Day, Year)	32 Regist	rar's Signature	A.	3101	0			. (11	174		2111
	Registr		NOV 1 5 200	6 Bers	JA ,	EXOR!	and the same							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 0 0 6 36093 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^Dg, 2006 November **Physician** Evering, Sr. George С. 5:30 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Dulaney Towson Health Care Towson 7. Age (In yrs. last birthday) 88 Yre If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**X** M 2□ F 1918 Maryland 218-09-9190 Director Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location itam 27 is markad other than "natural", or items 23a or 28a-1 show other traumatic event, the Modical Examiner: stat be notified at 1 Yes 2 No Baldwin Baltimore Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21013 4604 Langshire Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "n any injury or other traumatic event, the Medical page. Elementary/Secondary (0-12) College (1-4or 5+) Law Attorney 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Catherine Kuhn George Adam Evering 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4604 Langshire Rd. Baldwin, Md. 21013 Mrs. Mary Lee Evering/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Co. 11-13-06 Towson, Md. * 4 □ Donation 5 □ Other (Specify) ^{22. Name} Ruck fowson, Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 21. Signature of Funeral Service Licenses Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease Immediate Cause (Final disease or condition resulting in death) ACUTE Physician Hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 nknown cete has been sig ; page 2 should b 24a. Was an autopsy performed?
1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificete has the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 EN/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 27. Manner of Death

1 X Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No M within 24 hours after death To the Funeral Director: A 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled In by 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 1-0012849 7600 ESLER Dr. TOWSON MD 21204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. GHILADI.M 32. Relistrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 5 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State of Marylar		artment of H rtificate of L			ene2 () () 6 j. No.	36094
			1. Decedent's Name (First, Middle, Last)				2. Date of Death , Month	Day Year	3. Time of Death
п	Physici /Medic		Demick A.	Fowlke	S . <	٠, ٣		Vovember	10 200	. (9//) . M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ath
			The Johns Hookin	5 Hospital		Baltin	nove Ci	ty	NA	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bi	rthplace (State or Foreign country)
	Director		212-96-8742	JM 2□F 27	Yrs.			(Month, Day,) 6–13–19	979	Md.
	P .		Usual Residence of Decedent 10a. State 10b. County	100 0	ity, Town or Lo	nation				10d. Inside City Limits
	anyla phoy	_	Md. 10b. County	100.0	Baltin					1 ZYes 2 □ No
	Ba-f	cto				1		40.	China of Min of C	aunta (2
	3a or 2	i Director	7 S. Ellwoood Ave	enue		10f. Zip Code 2122	24	100	g. Citizen of What C USA	ountry :
	me 2	Jera	11. Marital Status	12. Was Decedent Ever in L	J.S. 13.	Was Decedent of Hi	ispanic Origin? (Spe n, Mexican, Puerto F	city Yes or No-	14. Race - Am Black, Wh	
and 21215-0036	within 72 hours after deeth with the Maryland liane. Then "naturel", or iteme 23s or 28s-f ehow the Madical Examinar must be notified at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2🌠 No	Specify:	ticati, etc./		Black
ŏ	2 hou	Completed	15. Decedent's Edu		16a. Dece	dent's Usual Occupa	ation		b. Kind of Busines:	s/Industry
끘	n'n'n	pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of workir i)			
2	d within plane. rr then	E O	12th grade		Phai	macy Tec	ch.		ionument I	Pharmacy
פַ	be filed tal Hygir d other	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma		
lar	75 E O A	To E	Wilbert		Fowlkes	5	Lois		Humble	es
A S	& SEE	e i	19a. Informant's Name/Relationship (T	ype, Print)	19b. Maili	ng Address (Street a	and Number or Rura	Route Number, (City or Town, State,	Zip Code)
Σ	1 and 2 Heelth a Iem 27 is		Ericka Fowlkes	Sister	190)1 Glenrot	ths Drive,		on, Md. 2	21009
Je.	item oth		20a. Method of Disposition		Place of Dispe cemetery, cre	osition (Name of matory or other place		ate 20	Oc. Location - City o	r Town, State
Ë	Pages nert of 1 int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify		t. Zion	n Cem.	11-16	5 - 06 I	ansdowne	, Md.
Baltimore, Mary	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	N 2 0 0 0 0		2. Name and Addres	ss of Facility M	March F.H	H. East More, Md	21202
	_		23a. Part1. Enter the disease, or comp	lications that caused the dea						Approximate
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.		,				Interval Between Onset and Death
ў I	Physician		disease or condition resulting in death)	. Hyper Kul	emica					1 day
	/Medical Examiner			Due lo (or as a conse	quence of):					3
1		_	Sequentially list conditions,	b. Kenal +a	iore.					Supars
	sit ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	220 10 101 40 2 001100	40000 0./.					
	and and I-tran	xan	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):					
8760,	The law requires that the death centificate be executed ate has been signed by the ettending physicien and paga 2 should be datached for use as the burial-transit			,						
87	physi the t	dical		d						
9 x	eath certific ettending p for use as f	/Me	IF FEMALE:	23c. If yes, outcome of pregr	nancv				23d. Date of de	alivery
Вох	etten etten for us	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Fet 4 Pregnant at time of	al death 3	☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
o.	t the de by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
0	thet ti ed by datac		Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	inderlying cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
Records,	signed be da	Completed by	Lupus Nephritis	Hupertensin	\sim			1 ☐ Yes	2 0 3 F	Probably 4 Unknown
Ö	w require been si should I	ete		, 11	,_,			24a. Was an	24h Were s	autopsy findings available
Sec.	elaw hasi	npl						autopsy	prior to	completion of cause of
=	: The l	S						1 ☐ Yes 2	XNo 1 ☐ Ye	s 2 No
of Vital	Physician: The this cartificete ral director, pages	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	26. Place of Death			
£	Physic this al dir	2	1 Yes 20 No	inpatient 2L	ER/Outpatie	nt 3 DOA	4 Nursing nor	ne 5 Residen 28d. Describe how	ce 6 Other (Sp	ecify)
	ing After	-CO	27. Manner of Death Death S ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	k?	200. Describe non	riquiy occurred	
Si Si	Attending in death. cotor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	20f Logation /Stra	ant and Number or f	Rural Route Number,
Division	l or At efter of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec		reet, factory, office	•	City or Town,		igrai riodio ivalidos,
	urs e urs e rai E		Continue The	yaldan: To the best of my k-	Contrades (fine	the Comment of the time	no data and filesa 3	and due to the one	sole) and manner	ne etatod
	To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	Medical		iner: On the basis of examinand manner stated.						
	ithin orthe orthe	Me	29b. Signature and title of certifier	۸>- ۱		29c. Licens	e number	296	d. Date signed (Mor	nth, Day, Year)
	F 3 F 8		1 M	and I - M	>	REC	2-000	K	lavo Lor	10.2001
j			30. Name and address of person who	completed cause of death (he	m 23a\ /Tucc				levember	1000
1)	1		Music III	(A) I	Varth Wa	ife St.	Battimin	e MD =	21287
	C.	210	31. Date filed (Month, Day, Year)	32. Restrar's Sign	nature	201 440	,,,,,	١١١١١٠١٠	1	- 01
	Regist	ate rar		006 Magne	B A	book	oife St.			
			(1 W) B U =		7 -					

				State of Maryland / Department of Health and		giene 006	36095				
				1 - For State Registrar Certificate of Death		ieg. No.					
_		Physicia /Medic		Decedent's Name (First, Middle, Last) HENRY WINFIELD FOSTER	2. Date of Dea Month	Day Year	3. Time of Death				
		Examin	- 4	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	ath	4c. County of Death					
				CARROLL HOSPITAL CENTER WESTMINSTER		CARROLL	de la Charles				
		Funeral Director		5. Social Security Number 218-18-3911 6. Sex 218-18-3911 7. Age (In yrs. last birthday) 82 Yrs. If Under 1 Year If Under 24 Hr		y, Year) 9. Birth Court	place (State or Foreign htry) YLAND				
		D >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			Od. Inside City Limits				
>		farylan	ō	AND GENT MORED			1 ☐ Yes 2X No				
HENRY		28a-	Director	MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	ntry?				
2		h with	O I	3725 RIDGE RD. 21157		USA					
H		deet	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A Black, W							
	36	hours after deeth with the Maryland turel', or items 23s or 28s-f ehow si Exartinal mast be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 💆 Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 🛣 No Specify:		C/4	ITE				
B	9	ture	ed p	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/In					
FOSTER	215	within 72 ene. then "nat	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of wife. DO NOT use retired)	orking						
8	212	filed with Hygiene other the	Сош	12 TEST MAN		PELEPHONE	CO.				
M	Maryland 21215-0036	ed ita	To Be (The factor of th	ame <i>(First, Middl</i> e, ZABETH	Maiden Sumame) MISTER					
	Mary	s 1 and 2 should f Health and Men item 27 ie marke other treumatic	_	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (Street and Number or to the street and N							
	ė,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tre		20a Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or Te					
	ē	Pages ent of nt: If it		1⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MEADOW BRANCH CEM. 11/	17/06	WESTMINSTE	R, MD				
	Baltimore,	partme partme portar / injur		21. Signature of Figure 1 Service Licensee 22. Name and Address of Facility F	LETCHER						
	ä	Depa Impo any i		254 E. MAIN ST.	-		21157				
•		Physician /Medical		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE ISCHEMIC STROK Due to (or as a consequence of): ATCIAL FIBRILIATION		rest,	Approximate Interval Between Onset and Death				
		Examiner		ATRIAL FIBRILLATION							
	7	uires thet the death certificate be executed signed by the ettending physicien and die detached for use as the burial-transit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
	V		Examiner	Cause (Disease or righty that intiated events resulting in death) Last Due to (or as a consequence of):							
	760		calE	d							
	68	tificat ng phy es the	Medic		***************************************						
	Division of Vital Records, P.O. Box 68	The law requires that the death certificate ate has been signed by the ettending physogge 2 should be detached for use es the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[\text{Yes} \ 2 \] No 9 \[\text{Unknown} \] 23c. If yes, outcome of pregnancy 1 \[\text{Live birth} \ 2 \] Fetal death 3 \[\text{Ectopic pregnancy} \] 4 \[\text{Pregnant at time of death} \] 9 \[\text{Unknown} \]		23d. Date of deliv Month	ery Day Year				
	Ρ.	thet the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to t	he cause of death?				
	rds	quires n sign uld be	ed by	HEMORAHAKIC PERICARDIAL EPFLISION	1 🗆 1	res 2 No 3 Pro	bably 4 □Unknown				
	S	sician: The law requir certificate has been si rector, page 2 should	Completed		24a. Was		opsy findings available empletion of cause of				
	R		Com		perfo	rmed? death? 2 No 1 ☐ Yes					
	/ita	cian: ertifica	Be	avaminar?	eath (Check only o	ne)					
	of V	physic this co	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Care: 4 Nursing		dence 6 Other (Speci	fy)				
	on	ding F h. After funer	tion	27. Manner of Death Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	200. 263011561	iow injury occurred					
	ivisi	r Attener de de de de de de de de de de de de de	Certification:	2 Accident 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)	281. Location (S City or Tov	Street and Number or Rur vn, State)	al Route Number,				
	Q	To the Hospitel or Attending Physicien: within 24 hours after death To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	ice, and due to the	cause(s) and manner as	stated.				
		the Ho in 24 h the Fu	Medicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.							
	N	with Con	2	29b. Signature and title of certifier 29c. License number D 3026		29d. Date signed (Month,	_				
	(11		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO, MD ZOO MEMORIAL AVENUE THE PROPERTY OF TH	E, WEST	NINSTER, ME	21157				
	6	Sta Regist	ate rar	31. Date liled (Month, Day, Year) 32. P. gi trar's Signature							
				NOV 1 5 2006 Breve & Backs							

DHMH 17 Rev 1/2001

Examiner The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, attending | MABEL FLETCHER cate has been sign, page 2 should be this certificate or Attending Physician: director. After the Certification: 5 Pending investigation death. within 24 hours after death To the Funerel Diractor; / completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide the Hospital TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier

t ☐ Yes 2 ☐ No

29c. License numbe

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD.

31. Date filed (Month, Day, Year) State

32. Registrar's Signature 2006 NOV

TIMONIUM, MD 21093

Registrar

Maryland 21215-0036

Baltimore,

NOVEMBER

			For State Registrar		S	tate o	f Maryla	and / Depa <i>Cei</i>	artment o	of He	ealth a Death	and Me		giene			36097
			1. Decedent's Nam	e (First, Midd	le, Last)		-						2. Date of De				3. Time of Death
	Physici		Jewel Ford							Nov 7,					/ Yea	3:30P M	
	/Medic Examin		4a. Facility Name (If not institutio	n, give stree	et and nur	nber)		4b. City, To	wn, or l	Location o	of Death		4c.	County of De	ath	
			Holy Cros	and Nu	rsing	Center		Burto					Mo	ontgomer	у		
	Funeral		5. Social Security N		6. Sex 1 ☐ M	XX ₽	7. Age (In yi	rs. last birthday)	If Under 1 \ Months D	ear ays	If Under:	24 Hrs.	B. Date of Bit (Month, Da	th ay, Year)	9. E	Sirthplac Country	ce (State or Foreign
	Director		260-30-83		10.00		92	Yrs.					Aug 29,	1914			GA
	and		Usual Residence o 10a. State	10b. County	,		10c.	City, Town or Lo	cation							10d.	. Inside City Limits
	Maryl Haho	ō	MD	Montgo	nery		Si	lver Spri	ing								1 ☐ Yes 2 No
	the 28e	rec	10e. Street and Nu	mber					10f. Zip Co	ode				10g. Citi	zen of What	Country	1?
	3a or	Funeral Director	14510 Hom	ecrest F	₹d	20906									USA		
	ms 2	nera	11. Marital Status				dent Ever in	U.S. 13.	Was Deceden	t of His	panic Ori	gin? (Spec	ify Yes or No)-	14. Race - Ar		
9	after or ite		1 Never Marr	ried 2 Mar	ried '	Armed Fo 1	2 X No		ii res, specily 1 □ Yes ××		Specify:	i, rusito n	ican, etc.)		Black, Wi		
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28e-f show Ita Madical Examiner mant be notilled at	Completed by	₩ Widowed	4 Divorced	1 .	Year or D	ates:		103 20	1140	ороспу.				Specify:	Whit	
ις. O	72 h 'natu	ete	(Spac	15. Deceder cify only highe				(Give	dent's Usual C kind of work	ione du		t of working	9	16b. Ki	nd of Busines	ss/Indus	itry
2	vithin ne. hen	E G	Elementary/Seco	ondary (0-12)	(College (1	-4or 5+)	//re.	DO NOT use						O 11	.=0	
2	Hygie Hygie ther t		12 17. Father's Name	(First Middle	(ast)				Homema		18. Mothe	r's Name /	First, Middle	Maiden	Own H	ome	
anc	ntal hed of	Ве	17. 1 48.01 3 744.110		liams								liggins		,		
Maryland	should ad Me mark matic	၉	19a. Informant's N	ame/Relation:	ship (Type,	Print)		19b. Mailir	ng Address (S	treet ar	nd Numbe	r or Rural	Route Numb	er, City o	r Town, State	, Zip Co	 ode)
≅	od 2 s lith ar 27 is 1 treu		Arthur R.			Son			Floating					20724			
ē	Hea Hea Hem Hem other		20a. Method of Dis	position			20b	. Place of Dispo	sition (Name	of r place	1	Da	te	20c. Lo	cation - City	or Town	, State
altimore,	ages ent of nt: if i		1 🔀 Burial 2 4 □ Donation			oval from	State St	Luke's	- 15		' i			Bluf	fton, S	C 299	910
≣	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel; or items 23a or 28e-f show appring or other treumatic event, the Madical Examinat must be notified at once.		21. Sign usre of Fi	1			/	2	Name and A	ddress	of Facility	у р л					
Ã	Den Sany Pary Pary Pary Pary Pary Pary Pary Par	68 1	K.\Gre	gory Fil	k MD	1148	1		26 Crai				urnie, M	ID 21	061		
			23a. Part1. Enter t	the disease o	r complication	ns that c	aused the de	ath. Do not ent	er the mode o	f dying,	, such as	cardiac or	respiratory a	rrest,		Ap	pproximate Iterval Between
	Pnysician	.	Immediate Cause disease or condition	(Final	2011) 0100 0			tive	1.	-1-	400	cile					nset and Death
	/Medical		resulting in death))II	a	Due to	or irs a cons		nea	1.1	374	CIVI				1	
	Examiner		Sequentially list conditions, b. Charchic Renal failure														
	n 11/2 =	ner	it any, leading to in cause. Enter Unde	nmediate eriving	or as a cons	equence of):		4									
	nd A	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):														
Ő,	e exection a	Ĕ															
8760,	ficate be executed physicien and the burial-transit	dicai			d										-	-	
တ	ertific ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy										23d. Date of delivery				
Вох	atten for us	ian	23b. Was decedent in the past 12	months?		1 Live b	irth 2 Fe	etal death 3	Ectopic pregi					1	Month	Da	y Year
o.	that the death certifi ed by the attending detached for use as	Physician/Me	1 ☐ Yes 2[9 ☐ Unknown			9□Unkno		, dodin o c	J Other (apoci	9/							
Δ.	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use a	Ph.	Part II. Other signi	ficant conditi	ons contrib	uting to de	eath but not r	esulting in the u	nderlying caus	e giver	n in Part I.		23e. Did tobacco use contribute to the cause of dea			ause of death?	
Vital Records,	uires sigr	d by											1 🗆	Yes 2[□No 3□!	Probabl	ly 4 BUnknown
000	w requir been si should	Completed											24a. Was		24b. Were	autopsy	findings available
Re	he lav e has age 2	E C												rmed?	prior to death? 1 🔲 Ye	?	letion of cause of
ta		BeC	25. Was case refer	rred to medica	al .						26. Place	of Death /	1 ☐ Yes Check only o				<u></u>
<u> </u>	9 s =	To B	examiner? 1 🗌 Yes 2 🔀	K No	Hosp	ital: 1 🗆 I	npatient 2	☐ ER/Outpatien	t 3 DOA	Other					3 □Other (Sp	pecify)	
o t	문 등교		27. Manner of Deat			8a. Date	of Injury th, Day Year)	28b. Time of Injury	28c.	Injury a	at		d. Describe				
0	Attending r death. ector: Afte by the fune	atic	1 Natural 2 Accident	5 Pendii invest	igation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , , , , ,	,,	М		es 2 □ i	No					
Division	i or Attende efter deatl Director: i in by the	Certification:	3 Suicide 4 Homicide	6 Could determ		8e. Place buildii	of Injury - At	home, farm, str	eet, factory, o	ffice		28	If. Location (City or Tox	Street and wn, State,	d Number or i	Rurai R	oute Number,
	itei o irs eft rei Di led ir	Cer			1												
	Hosp 4 hou Fune ely fil	icai	29a. Certifier (Check only		Exeminer:	On the ba	asis of exami	nowledge, death nation and/or in									
	To the Hospitel or Attent within 24 hours efter deat To the Funerel Director: completely filled in by the	Medicai	one) 29b. Signature and	I title of cortific		and manr	ner stated.		290 1	icense	number			29d. Dat	e signed (Mo	nth. Dav	v. Year)
	Twit Col	-	250. Oignature and	الم الله	250				00	205	1: 5	1.1		11/5	3106		
	1			10		-1-4		00-\ C	Deins)		731	06		1.1 3	7,00		
	5		30. Name and add	- 1		eted caus	e or death (It	ет 23a) (Туре,	7500c	6.		, ich	230 -	7.7.	0	, 0	21200
	Sta	te.	31. Date filed (Mon			32 R	egistrar's Sig	nature	OFTU	CCC	10.3	~ / 12		ULU	2010 L	<u> </u>	21286
	Registr		N	OV 1 5	2006		Defiled.	15 60	and s								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** GRACE 11 1315 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8 Beacon Hill Road Baltimore Gwynn Oak Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 🗆 🗗 Yrs. 86 12/28/1919 WV Director 214-38-3388 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Gwynn Oak Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zin Code 21207 USA 8 Beacon Hill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify Specify: þ 3 Widowed 4 Divorced White "natural" Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Health Care Facility Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Grace Catherine Patrick မ Aurthur G. Yates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health Steven Maurca/Friend 17 Highfields Drive Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 Surial 2 ☐ Cremation 3 ☐Removal from State Nov 4 ☐ Donation 5 ☐ Other (Specify) 2006 Woodlawn, Maryland Lorraine Park Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and bunial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown החיפו נוווס sertificate has been signed by funeral director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ No No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒️No 24a. Was an autopsy performed? Yes 201 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home Sesidence 6 ☐ Other (Specify) 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and WP

D State

Registrar

31. Date filed (Month, Day, Year)

VICTOR WADRID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 12, 2006 Month **Physician** Charles William Gouldin, Jr. November 10:30 PM /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Future Care Cherrywood Health/Rehab. Reisterstown 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) July 22, 1941 5. Social Security Number 6. Sex **Funeral** 10XM 2□ F Maryland Director 213-40-0939 65 Usuel Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Iteme 23e or 28e-f show traumatic event, the Madical Examiner must be notitied at 1 Yes 2 No by Funeral Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21223 322 South Woodyear Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2000 If Yes, Give Year or Dates: ₩₩Wever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Disabled unknown Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permi. Pages 1 and 2 should be filt.
Department of Health and Mental by Important; if Item 27 is marked oth any injury or other traumatic event State. Be Charles William Gouldin, Sr. Bernice Overend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 768 Seawall Road, Baltimore, Maryland 21221 Karen Weaver (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 11/15/2006 Brooklyn Park, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Public inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** brienhibpathe /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): the attending physician ched for use as the buria Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 ☑ No funeral 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 29a. Certifie 1 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D47683 14/26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V Raymond Mille Street Reintestown AA 21136 Main Sinte 200 31. Date (Month, Day, Year) 32. Registrar's Signature State spake. Registrar DHMH 17 Rev 1/2001

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25. Was case referred to medical examiner? Hospital: Applications of Death (Check only one) Cither: 4 Designation of Death (Check only one)			
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27. Manner of Death 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury oc	n (Street and Number or Rural Route Number, Town, State)		
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The state of the s			
and manner stated. 29c. License number 29d. Date signed (Month, Day, Year))		
Mamatten MD RES 001 November 11 2)		
DR. Mamatha Prabhakon, 3001, S. Hanover Street, Baltimore, MD-21	206		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar NOV 1.5. 2006	206		

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla	and / Depa <i>Cei</i>	artment o	f Health a of Death	ind Menta	al Hygien		36101	
	Physici		1. Decedent's Name (First, Middle, Last) MANY E.	ite of Death	Day 2006	3. Time of Death 534 PM						
	/Medio Examin		4a. Facility Name (Y not institution, give is UNIVERSITY of MARY	and Medical	(after	4b. City, Tow	oses		kc. County of Dea			
	Funeral Director		5. Social Security Number 6. Sex 214-44-0556 Usual Residence of Decedent	M 20 F 7. Age (In yo	rs. last birthday) Yrs.	If Under 1 Y	ear If Under 2 ays Hours	Min. (M	te of Birth onth, Day, Yea b. 03,1	ir) C	thplace (State or Foreign ountry) aryland	
	Maryland If show	tor	10a. State 10b. County Maryland N/A	10c.	City, Town or Lo Baltimo						10d. Inside City Limits 1 ✓ Yes 2 ☐ No	
	h with the 23s or 28s	al Director	10e. Street and Number 600 Light Street	Apt. 628	10f. Zip Code 21230						ountry?	
980	72 hours after death with the Maryland natural', or itama 23a or 28a-f ehow dical Examinar munt be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	rmed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 ☑ No ☐ Yes 2 ☑ No Specify: Soe						14. Race - American Indian, Black, White, etc. White Specify:	
Baltimore, Maryland 21215-0036	within 72 iane. than "naithe Medic	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed) College (1-4or 5+)	of working		Kind of Business					
yland	should be filed ind Mental Hygi a marked other umatic avant,	To Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) The line First, Middle, Maiden Sumame)									
, Mar	d 2 ar 17 la trau		Michael Gisriel	(Son)	3809	Fairha	ven Aver	nue, Ba	ltimore	, Maryla	and 21226	
imore	9 to 1		20a. Method of Disposition 1 ₩ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State C	edar Hil	.1 Ceme	tery 1	Date 11-14-0	6 Bal	·	Maryland	
Ball	permit. Pag Department Importent: any Injury o		21. Signature of Funeral Service License	Janus						P.A. ore, Mar	yland 21230	
,	Physician /Medical Examiner		23a. Part. Enter the disease, or complications, or heart failure. List only on Imprediate Cause (Final disease or condition resulting in death)	cations that caused the de é cause on each line.	ary a	rter mode of	1	cardiac or resp			Approximate Interval Between Onset and Death	
8760,	cate be executed physician and tha burial-transit	al Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons								
.O. Box 687	he deeth certifi the attending thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{Mo} \) 9 \(\text{Unknown} \)	3c. If yes, outcome of prediction of the second of the se	etal death 3	Ectopic pregn				23d. Date of de Month	Day Year	
<u>α</u>	w requires thet the state of th	þ	Part II. Other significant conditions con	2	3e. Did tobacco	_ \	o the cause of death? robably 4 □Unknown					
of Vital Records,	The ate h page	Completed	7					_	4a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s 227No	
Vita	Phyalclan: T this certificat ral director, p	Be	25. Was case referred to medical examiner?	ospital:			Othor	of Death (Che				
	Phya r this ral di	. To	1 No 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of		Injury at Work?		Residence escribe how in	6 □Other (Spe jury occurred	ecify)	
ion	Attending I ir death. actor: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury		Work? 1 ☐ Yes 2 ☐ N	10				
Division	in Figure	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, of	fice		cation (Street ity or Town, Sta		lural Route Number.	
	To the Hospital within 24 hours e To the Funeral Completely filled	ledical (29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, death ination and/or in-	n occurred at the vestigation, in a	ne time, date and my opinion, deat	d place, and du h occurred at t	e to the cause he time, date a	s) and manner a nd place, and du	s stated. e to the cause(s)	
	To the within To the Comp	W	29b. Signature and title of centifier	2 Atlendin Phys	gician	12	ense number 437	42	1	Date signed (Moni	06	
	Sto	ta	30. Name and address of person who co	mpleted cause of death (I	3	Print) Str	eet, six	th floor	r, suite	des, Ra	Himas, MD	
	Sta	ne	11 2 1 1 1 2 200 F	Patrick State of	15 1190							

State of Maryland / Department of Health and Mental Hygiene State Amend #1, perMD, G862, 12/13/06 TT

Certificate of Department Certificate of Department of Department Of Reg. No... 1. Decedent's Name (First, Middle, Last)

Suzanne M. Garland 2. Date of Death Month Nov. Ogy 2006 **Physician** 9:30 РМ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia Howard County General If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 22, 1948 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 X F Mary land 58 Director 213-54-5044 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 28a-f show at 1 ☐ Yes 2 ☐ No the Medical Examiner must be notified Director Laurel Anne Arundal Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö United States America 20724 3509 Rippling Way items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 🙀 No 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☐ KNo altimore, Maryland 21215-0036 "natural", or Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Director Cosmotology 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown Pierre Theis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maryland 20724 3509 Rippling Way Laurel Ray Gobble/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Catonsville, Maryland 11/10/2006 5 Other (Specify) Metro Crematory 4 Donation 22. Name and Address of Facility 21. Signature of uneral Service Licensee 7601 Sandy Spring Road Laurel, Maryland Fleck Funeral Home 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hdynocarcinina disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Nnpatient 2 ER/Outpatient 3□ DOA 1 ☐ Yes Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death.

I Director: After to in by the funeral 1 Natural 2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30573 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patoxint Parkway Colombia MD 21044 22011 700 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 5 Registrar

			1 - For State of M	laryland / Dep <i>Ce</i>	artment of Hertificate of L			ene 006	36103
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	/Medic		Nunnie Gree		4h City Town or	Location of Death	11	11 06 4c. County of Deat	10100m
	Examin	er	4a. Facility Name (If not institution, give street and number	Hosm tol	R & H	Location or Death	MD	N/A	1
	Funeral Director			ge (In yrs. ast birthday 69 Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth SEPT 23	9. Birti	nplace (State or Foreign untry)
	70		Usual Residence of Decedent	10c. City, Town or L					10d. Inside City Limits
	Marylar -f ahov	tor	10a. State 10b. County N/A	BALTIM					1 Yes 2 No
	3a or 28e	al Director	10e. Street and Number 4706 PIMLICO ROAD		10f. Zip Code 2	1215	10	g. Citizen of What Co USA	untry?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28e-f ahow stry injury or other traumatic avent, the Mudical Exartinal result is incilling at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Deceden Armed Forces 1 □ Yes 2 ☑ 14. Yes 2 ☑ 15. Yes 6 ☑ 16. Yes 6 ☑ 16. Yes 6 ☑ 17. Was Deceden Armed Forces 1 □ Yes 6 ☑ 18. Was Deceden Armed Forces 1 □ Yes 6 ☑ 19. Was Deceden Armed Forces	t Ever in U.S. 13.	. Was Decedent of Hi If Yes, specify Cuba 1 Yes ZE No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: BL	e, etc.
215-0	within 72 ho ene. then "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Giv	edent's Usual Occupa e kind of work done o DO NOT use retired	luring most of works	ng 1	6b. Kind of Business/	
2	filed with Hygiene Ather that	Con	12TH		CASHIER		(5) A (1) A	SUPER MARI	KET
Maryland	should be fill and Mental H in marked oth umatic aven	To Be	17. Father's Name (First, Middle, Last) TONY BUTLER SR.			18. Mother's Name) (First, Middle, M	aiden Sumame)	
Man	and 2 sho ealth and I n 27 is me		19a. Informant's Name/Relationship (Type, Print) SABERNIA FRESNEL (grandchi		-			City or Town, State, 2 LL,MD.210	
nore,	ages 1 and nt of Health t: If Itam 27 f or other tr		20a. Method of Disposition ★Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Disp cemetery, cre	ematory or other place			Oc. Location - City or	
Baltimore,	4 Donation 5 Other (Specify) ORUID RIDGE CEM. NOV.17,2006 PALTO. CO,MD. 22. Name and Address of Facility ORUID RIDGE CEM. NOV.17,2006 PALTO. CO,MD. 22. Name and Address of Facility ORUID RIDGE CEM. NOV.17,2006 PALTO. CO,MD. 22. Name and Address of Facility ORUID RIDGE CEM. NOV.17,2006 PALTO. CO,MD. 21. Signature of Funeral Service Licensee ORUID RIDGE CEM. NOV.17,2006 PALTO. CO,MD.								
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8760	cate b	dlca	d. 6a	Stroin-	testu	-21 12	olee o	(np	
O. Box 6	law requires that the death certificate be as been signed by the ettending physicie? Should be detached for use as the but	Physician/Medical		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of del Month	ivery Day Year
σ.	s that t	by Ph	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause give	on in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ord	w requires that s been signed t should be deta	eted	End stose ver	121 d	rsen	Se	1 🗌 Ye		obably 4 Unknown
Vital Records,	The ate h page	Completed	Sacra dear	ortus	alce	<u></u>	24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of 2 No
/ita	Physician: Th ribis certificate ral director, pag	Be	25. Was case referred to medical examiner?		0	26. Place of Death	(Check only one)	
of	S S	lon: To	27. Manner of Death 1 Matural 5 Pending (Month, D	ury 28b. Time	of 28c. Injury Work	at at	me 5 Resider 28d. Describe how	ce 6 □Other (Spectron occurred	city)
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Ir building, 6	njury - At home, farm, s atc. (Specify)			28f. Location (Str. City or Town,	eet and Number or Ru State)	iral Route Number,
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	To the within 2 To the complet	Mec	29b. Signature and lytle of certifier		29c. License	e number	29	d. Date signed (Mont	h. Day, Year)
	h		The moderation	ulln	m Doc	6391	7	11/12/	06
	3		30. Name and address of person who completed cause of	death (Item 23a) (Type	B21	time	re M	D 217	139
	Sta Registi			trar's Signature	fearle)		-		

David Huff 06-08487 **UNK UNK**

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Month Day November 8, 2006 Medical Examiner 0433 hrs 4b. City, Town, or Location of Death c. County of Death 4900 East Lombard Street Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 9. Birthplace (State or **Funeral** Months Days Hours Min. Director unk 1 M 2 Country) Usual Residence of Decedent 10b. County 10d Inside City Limits 10a. State Town or Location Yes 2 No 23a or 28a-f show notified at once. hours after death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number Funeral 11 Marital-Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 Never Married Married Yes If Yes. Give Year Yes 2 No specify: Widowed 4 Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 15 Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Pages 1 and 2 should be fited within 72 I nent of Health and Mental Hygiene. ant: If item 27 is marked other than "or other traumatic event, the Medical Is Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 18 Mother's Name (First, Middle, Be ဥ Informant's Name/Relation State, Zip Code) 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition 20c. Location crematory or other place) Cremation 3 Burial 2 Removal from State Department o Important: injury or oth Donation 5 Other, Specify 22. Name and Address of Facility 21. Signat of of Fune Se i - c -: (TARN PMARCH IUNERA/ADME complications that caused the death. Do not enter the no le of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** ai ure ist only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Imme at Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical sician urial -UNPENDED AMENDED Box 68760 attending phys for use as the bu IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown y the ? Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ð Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No page 2 No certificate 1 Ves 25. Was case referred to medical 26 Place of Death (Check only one To the Hospital or Attending Physician: Be Other₄ examiner? Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other Scene After this 2 ۵ 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Pedestrian struck by motor vehicle **FOUND** Natural 1 Yes 2 V No 5 Pending To the Funeral Director: Nov 8, 2006 0400 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town State determined (Specify) Interstate/Express 4900 East Lombard Street, Baltimore, MD Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d Date signed (Month, Day, Year) O.C.M.E November 8, 2006

DHMH 17 Rev 1/2001

Pamela E. Southall, MD 31 Date filed (Month, Day, Year) State

Assistant Medical Examiner 32. Registrar's Signature

Nam and and ress of person what completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

Registra

06-08617 Wayne Brantley Harris, Jr.

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 36105

		- For State	Certificate of Death Reg. No.									
Physiciar Nedical Examin	1/	1. Decedent's Name (First, Middle, Wayne	Last) B	B Harris Jr 2. Date of Death Month Day November 12,						3. Time of Death 1740 hrs		
	4a. Facility Name (if not institution, give street and number) University of Maryland Hospital						4b. City, Town, or Location of Death 4c. Count Baltimore					
Funeral Director		219-98-2128	2128 1 N 2 F 39 Yrs. Months Days Hours Min. May 27 1967									
Maryland 28a-f show any 1 at once.		Usual Residence of Decedent 10a. State 10b. County Maryland Anne A		10c. City, Tow	n or Locatio	in				10d. Inside City Limits 1 Yes 2 X No		
the Maryl a or 28a-f	Director	10e. Street and Number 1550 Monard Av	е.			10f. Zip Code 21144		1	log. Citizen of Wh	at Country?		
s afte	by Fune	11. Marital Status 1 Never Married 2 Mari 3 Widowed 4 Divor 15. Decedent's Education (Specif	1 Yes 2 ced If Yes, Give Year or Dates:	X No	If Ye	s, specify Cuba	n, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.) nd of work done	White	white		
5-0036 led within 72 hours afte Hygien other than "natural", other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5			st of working life	e. DO NOT u	se retired)	Со	nstruction		
	Be	17. Father's Name (First, Middle, L Wayne	В	Harris				Name (First, Middle, Linda	S	Cashion		
MD 212 d 2 should be tth and Menta n 27 is marke aumatic even	٩	19a Informant's Name/Relationship Wayne B Harris		er	8237	Quaterf	ield I	er or Rural Route Nui Rd. Severn	Marylan	d 21144		
re, s l an f Hea ff iter		20a Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Spe	gifo:	crema	atory or other	n Cemet	ery	Date 11/17/2006	Glen Bu			
Balt permit Depart Impor	3111 Mountain Road Pasadena M									ryland 21122		
Physician /Medical xaminer	I Immediate Course (Final disease) a Bluist Force Head Injuries with Complications								est, snock, or nea	Approximate Interval Between Onset and Death		
1	۱,	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse							_		
1 "	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):								
A an and al - tra		UNPENDED	dAMENDED		<u> </u>							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkn	4 Pregnant at		2 Feta	al death 3 er (Specify)	Ectopic	pregnancy	23d. Date of Month	delivery Day Year		
P.O. B	اھ	Part II. Other significant conditio	ns contributing to death	but not result	ing in the ur	nderlying cause	given in Parl			bute to the cause of death? Probably 4 Unknown		
Division of Vital Records, tal or Attending Physician: The law requirers after death al Director: After this certificate has been seled in by the funeral director, page 2 should tal	Completed							1 🗸 Yes	psy p ormed? d	Vere autopsy findings available nor to completion of cause of eath? Yes 2 No		
cian:	Be	25. Was case referred to medical examiner?	Hospital: 1 / Inpatie	🗆 ===			Othor	Check only one)	1 D	Tour		
n of Vital I	의	1 Yes 2 No 27. Manner of Death	28a Date of Injur		Outpatient o. Time of In		ury at Work?	28d. Describe	Residence 6 how injury occurre	Other:		
ision (Attendin pr death rector: A	ation	1 Natural 5 Pendir 2 Accident Investi	gation		10 hrs		Yes 2	No ,	s assaulted			
Divis	Certification:	3 Suicide 6 Could determ				t, factory, office	building, etc.		Street and Numbe State) Irive, Annapolis	er or Rural Route Number, City		
To the Hosp within 24 hosp To the Func completely fi	Medical C	29a. Certifier 1 Certifying Phy	vsician: To the best of my iner:On the basis of exar and manner stated	knowledge, d	leath occurr r investigatio	ed at the time, o	date and place	ce, and due to the cau urred at the time, date	se(s) and manner and place, and di	as started. ue to the cause(s)		
F 3 F 3	ğ	29b. Signature and title of certifier					se number		29d. Date signe November	ed (Month, Day, Year) 13, 2006		
3		30. Name and address of person we pamela E. Southall, MI						ore, MD 21201				
Sta		31. Date filed (Morith Day, Year)	- 61	's Signature	0							
Registi	ĊĽ		S. S. S. S. S. S. S. S. S. S. S. S. S. S		57							

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 3, 3, PM 1. Decedent's Name (First, Middle, Last) Physician Μ 2006 Hackenberg Helen November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. July 25 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ √F 138-28-7385 90 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Health and Mental Hygiene.
ant: If Itsm 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic swent, it a Medical Exam an invative incitified. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 Falcon Dr. 21122 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 🖾 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Claims representative insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Κ. Ford Katherine Hinds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Whitmore daughter 209 Falcon Drive Pasadena Maryland 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Metro Crematory 11/17/06 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature (Funeral Service lice s 22. Name and Address of Facility Stallings Funeral Home P.A. <u>3111 Mountain Road Pasadena MD 21122</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition erebrovascul av Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Unpatient Certification: To 2 ER/Outpatient 3☐ DOA nours efter death.

neral Director: After this
filled in by the funeral d 27. Manper of Death 1 ☑Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier le to MD 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) Drive, Hen Burnie, ND 2 LOGO
(TOOVGE E. WICKS WITH 301 blospital Drive, Hen Burnie, ND 2 LOGO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 1 5 2006 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	arylan				ealth a		R	eg. No.	06	36107		
	Physici /Medic		1. Decedent's Name (First, Middle, Lat John William Heis								2. Date of Deat November		00 ^v 6 ^{ar}	3. Time of Death 7:00 A м		
The same	Examin		4a. Facility Name (If not institution, give 1224 East Riversi		-	Es	Location of			4c. Cour Ba						
	Funeral Director		5. Social Security Number 6. S 217 12 3773	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, March 25	,1919	(ear) 9. Birthplace (State or Fi Country) 1919 Maryland						
	Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor	re	10c. City	y, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 220No		
	or 28a-	Director	10e. Street and Number				10f. Zip				1	0g. Citizen o		intry?		
936	s within 72 hours after death with the Maryland liene. I then "naturel", or Items 23a or 28a-1 show I're Medical Evantiner must be profilled at	by Funerai	1224 East Riversic 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes, Give Year or Dates:						gin? (Spec , Puerto P	cify Yes or No- lican, etc.)		lace - Amer lack, White			
Maryland 21215-0036	within ene. then '	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5	+)	16a. Deced (Give life. Secur	kind of wo DO NOT u	rk done d se retired	luring most }	of workin	g	16b. Kind of Aero	Business/li	ndustry		
/land 2	id be filed ental Hyg ked othe ic avent,	0	17. Father's Name (First, Middle, Last) Robert Heise								(First, Middle, M Sporrer	Maiden Sum	ame)			
	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (Ethel Heise (Wife)	**		1	-				Route Number, enue Bal			y Code) yland 21221		
Baltimore,	o to T		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control o		a	lace of Dispo emetery, cren k Lawn	natory or o	ther plac				20c. Locatio Balti	-	own, State Maryland		
Baltii	permit. Pag Department Important: sny Injury o		21. Signature of Funeral Service Lices		lo .	22 F	Name ar Bruzd	ad Addres Zinsl	s of Facility Ki Fur	neral	Home F	A.	Marvl:	and 21221		
	Physician		23a Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused one cause on each lir	Θ.	n. Do not ent	er the mod	le of dyin	g, such as o	cardiac or				Approximate Interval Between Onset and Death		
	/Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequ	vence of): RDIAL	11074	アルド	FAILU ARCTI	W)						
المرون في ا	ate be executed hysiclen and the burial-transit	Examiner			of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											-
89	ificate bo g physic as the bu	edicai	•	d												
.O. Box	it the death certifica by the attending ph tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pr Other (sp				191		Date of deliv Month	ery Day Year		
<u>α</u>	quires that the signed by ald be detacted	þ	Part II. Other significant conditions of	ontributing to death be	ıt not resu	ulting in the u	nderlying o	ause give				id tobacco use contribute to the cause of death?				
Vital Records,	The law requires that the sele has been signed by the page 2 should be detache	Completed								_	24a. Was ar autops perform 1 Yes 2	ned?	o. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of		
Vita	iclan: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	-t 2 🗆	ER/Outpatien	t 3 DC	Othe	r.		(Check only one		wh /C	4.1		
o	ding After fune	tion; To	27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Da)	y	28b. Time of Injury		28c. Injury Work	7 140	2	8d. Describe ho			197		
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubulding, etc			eet, factor	y, office		21	Bf. Location (Str City or Town	Street and Number or Rural Route Number, wn, State)				
	To the Hospital or within 24 hours afte To the Funeral Dil completely filled in	edicai C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best on niner: On the basis of and manner sta	of my kno examinat ted.	wledge, death tion and/or inv	occurred restigation	at the tim	e, date and inion, deat	d place, ar h occurre	nd due to the ca d at the time, da	use(s) and rate and place	manner as s e, and due t	stated. o the cause(s)		
1	To the vithin To the compl	Me	29b. Signature and title of certifier	us up			290	D /	number 6619	9		od. Date sign				
	V		30. Name and address of person who	completed cause of d	eath (Item	The second second	14	. (/						40.21236		
	Sta Registr		31. Date (iled (Month, Day, Year)	32/Registra	r's Signa	idea page	NECT N	,								

State of Maryland / Department of Health and Mental Hygiene #19b per FH G861 11/15/06 JH Reg. No. Amend Item 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1220 Month **Physician** Hightauer Am Haywood /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner Balto, City Alice Manornursing Home 2095 RockRow Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. lest birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) Funeral Months Days 1 XM 2□ F Yrs 86 Director 526-20-1772
Usual Residence of Decedent death with the Merylend 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 Yes 2 No Director Baltimore r items 23a or 28e-f e NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21211 2095 Rockrose Ave Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Pages 1 end 2 should be filed within 72 hours efter d Depertment of Health end Mentel Hygiene. Important: if Item 27 is marked other than "naturel", or iten any injury or other traumatic event, the Medical Exprinant 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black δ 3 ☑ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Beth Steel Corp Coke Oven 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laura C. Hightower Harrison Hightower 19b. Mailing Appears 18/196 and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21207 Frankin Ave, Baltimore, Md Noel Hightower-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/20/06 Owings Mills, Md Garrison Forest Vet 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md Colmon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Mostrack Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No ANTV 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□No Hospital: edicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 Yes 2 No 24 hours after death Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hor To the Fune completely fi and manner stated. To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D 3146 MD 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 3 BALTIMBILE MD 2/201 SI finte 30 \$ SHOAII3 A. HASHMI & 21 N. EUTAN 31. Date filed (Month, Day, Year) 32" Registrar's Signature State NOV 1 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 = For State Registrar	State of Mai	-	epartment Certificate			ental Hy	giene Reg. No. 20	06	36109
	Physici /Medic		Decedent's Name (First, Middle, Last, Emma	Loui	.se	Н	orne		2. Date of De Month	Day	Year 2006	3. Time of Death
3	Examir Funeral	ner	4a. Facility Name (If not institution, give Since Hospital of 5. Social Security Number 6. Security Number 10. Security Number	Baltim 7. Age	(In yrs. last birtl	nday) If Under		ere Ci		4c. County		ace (State or Foreign TV)
- tor	Director Model		Usual Residence of Decedent 10a. State 10b. County MD NA		10c. City, Town Baltin	or Location				77 32	10	od. Inside City Limits
Emina L	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural', or Items 23e or 28e-f show any injury or other traumatic event, I'm Medical Exartener must be notified at ADES.	Completed by Funeral Director	10e. Street and Number 3909 Emmart Ave	12. Was Decedent Ev Armed Forces?	ver in U.S.	10f. Zip (2121		ify Yes or No		What Countries A	ny?
~	'2 hours afte hatural', or it ical Expren	ted by Fu	1 Never Married 2 Married Widowed 4 Divorced 15. Decedent's Edu	1 Yes 2 No If Yes, Give Year or Dates:	16a. I	1 ☐ Yes 2	No Spec	cify:		Specify 16b. Kind of Bu	Bla	ack
หนองก land 21215	filed within 7 Hygiene. ther than "n nt, ton Ned	Comple	(Specify only highest grade Elementary/Secondary (0·12) 11th grade 17. Father's Name (First, Middle, Last)	College (1-4or 5+))	Give kind of work life. DO NOT use Housew	ife			Ho , Maiden Sumarr	me	
+ Km aryland	should be fund Mental I	To Be	John S. Hawthor 19a. Informant's Name/Relationship (Ty		19b.	Mailing Address (01	telia	Ingra	a m		Code)
Pat lent Knwon as "Baltimore, Maryland 21215-0036	ges 1 and 2 at of Health a it item 27 is or other tra		Teresa Horne-Dau 20a. Method of Disposition 1 【XBurial 2 【Cremation 3 【R	_	20b. Place of I	Queen Disposition (Name or other crematory or other	e of ner place)	Dat	te	20c. Location -	City or Tow	
Baltim	permit. Pa Departmer important: any injury once.		4 Donation 5 Other (Specify) 21. Senting Funeral Service License	J. Ani	Garris	March	F/H We	est		06 Owin		ills, Md 21215
	Physician /Medical Examiner	Iner	23a. Pag1. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to annucleace ause. Enter Underfu	Due to (or as a	nalopat consequence of	thy 1):	of dying, such	as cardiac or i	respiratory a	rrest,	1	Approximate Interval Between Onset and Death OR WELLES
68760,5	tificate be executed g physicien and as the burial-transit	ledical Examiner	resulting in death) Last	Due to (or as a	consequence of	:):						
P.O. Box	The law requires that the death certificate has been signed by the ettending is age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	3□Ectopic pre- 5□ Other (spe-				23d. Dat Mor	te of delivery	y Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions cor	tributing to death but	not resulting in	the underlying car	use given in Pa	art I.	23e. Did t	obacco use contr		cause of death?
tal Rec		Completed	25. Was case referred to medical				00 81	leas of Dooth (1 Des	med? 0 2 □ No 1	death?	sy findings available pletion of cause of
Division of Vital Records,	this ald	Certification; To Be	examiner? 1 Yes 2 No H 27. Manny of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)		me of 28 ury M	Cther: 4 Cth	28i □No	5 ☐ Resid. Describe l	dence 6 Other	ed	
Divis		- 7	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury building, etc.	(Specify)				City or Tov			
	To the Mospital or within 24 hours after to the Funeral Dir completely filled in	Medical	(Check only 2 Medical Examinate) 29b. Signature and title of certifier	ner: On the basis of earth manner state	xamination and/	or investigation, i	n my opinion, o	death occurred er	at the time,	date and place, a 29d. Date signed	and due to the distance of the	he cause(s) ay, Year)
	10		30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (T	ppe, Print)	RES-1	000 R111	inan	Novem	ker	10,2006
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Physicia	an	Decedent's Name (First, Middle, Last, DAVID CLEAN						2. Date of D	Day	Year	3. Time of Death
/Medic		DAVID GLENN 4a. Facility Name (If not institution, give	HOLLEY			4b. Citv. Town. o	r Location of Death	NOVEM		3 2 00 Deal	6 1.10
Examin	er	SINAL HOSPITAL OF	0	ORE		BALTIM	ORF CIT	4		1	
Funeral		5. Social Security Number 6. Sec	7. Ag	e (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth lay, Year)	9. Birt	thplace (State or Foreign
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tar daa Iteme	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ Î		IS. W	Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	0- 14.	Black, White	
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ld be lantal ked c	0 8	ALEXANDER HOLLEY					GUISS	IE WII	LLIAMS		
shou and N	-	19a. Informant's Name/Relationship (Ty	rpe, Print)	1	9b. Mailing	g Address (Street	and Number or Rura	il Route Numb	ber, City or To	own, State, 2	Zip Code)
and 2 aalth n 27		BRENDA HOLLEY/WIFE	<u> </u>	Jan ai		5 EDGEMO	1		MORE, 1		217
ges 1 t of H if ite		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □ F	Removal from State	ceme	tery, crem	ition (Name of atory or other place	ce)	Date		tion - City or	
parmit. Pages 1 and 2 should be filad within loppartment of Haalth and Mantal Hygiena Important: if Item 27 is marked other than any injury or other traumatic event, the Magnes.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	90	MT.		CEMETER:		22-06			MARYLAND
parmi Dapa Impo any ii		21. Signal of Pulleral Service Literis	m.	ato			AURENS ST.				S F.H., INC.
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law raqu as baan 2 shout	plet	HYPERTENSION						24a. Was		4b. Were au	topsy findings available
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ar dae	Certification	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, c. (Specify)	farm, stre	et, factory, office		28f. Location ((Street and N	lumber or Ru	ıral Route Number,
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Hospital 24 hours a Funaral I	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best on ner: On the basis of and manner sta	examination	ige, death and/or invi	occurred at the tin estigation, in my o	ne, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)
To the Hospital or Attending F within 24 hours after death. To the Funaral Director: Atter completely filled in by the funer	Med	29b. Signature and title of certifier	1			29c. Licens				_	n. Day, Year)
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5		30. Name and address of person who co	empleted cause of de			Print)	0		JUNE PIL	~1\	
d-		JASON Hu, MD	S ₁		HOSPI	TAL O	S-000 E BALTI	MORÉ			
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			1 - For State Registrar	State	or maryla	na / Del Ca	partment of Heartificate of a	Death		ienez () () (5 36111
			1. Decedent's Name (First, Middle	, Last)					2. Date of Deat	h _	3. Time of Death
н	Physicia			Harry		J.	Ha	gner, si	Month Novembe	r 12, 200	
	/Medic Examin		4a. Facility Name (If not institution		ımber)			r Location of Dea		4c. County of D	eath
	LXuiiiii		Johns Hopkins	Bayview	Medica	1 Ctr.	Baltin	more			N/A
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs		Yearl 9.	Birthplace (State or Foreign Country)
	Director		218-18-9488	1 € M 2 ☐ F	81	Yrs.	Working Days	TIOUS IVIII	March		Marvland
	p		Usual Residence of Decedent		100.6	ity, Town or	Languisa				10d. Inside City Limits
	anyla ehov	_	10a. State 10b. County		100.0	ity, TOWIT OF	Location				1 ☐ Yes 2 ☐ No
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	or 2	Director	10e. Street and Number	3 70 3			10f. Zip Code		1	0g. Citizen of What	Country?
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٥	hours after death with the Maryland turel: or Itame 23a or 28a-f ehow al Exarch et must be notified at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☒ Marri	Armed Fo	2 🗌 No	U.S. 13	 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No 	lispanic Origin? () an, Mexican, Puei Specify:	Specify Yes or No- rto Rican, etc.)		merican Indian, hite, etc.
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ğ	d 2 shoulth and Mind Mind Mind Mind Mind Mind Mind Mi	1.9	19a. Informant's Name/Relationsh		(: C)		iling Address (Street				
	s 1 and if Health Item 27 other ti		Mrs. Shirley L	. Hagner			07 Eastfie	eld Road		, Mary Lat 20c. Location - City	
Ö	m 0		1 ☐ Burial 2X Cremation		Ctata	cemetery, cr	ematory or other place				
	mit. Pag bartment cortent: I Injury c		4 Donation 5 Other (Sp		пт		Service Co			Towson, N	
Baltimore,	permit. Page Department Important: I any Injury o		21. Signature of Funeral Service I	licensee			22. Name and Addre Duda-Ruck 7922 Wise				
			22a. Part1. Enter the disease or shock, or heart failure. List	complications that	caused the de						Approximate Interval Between
.	Physician		Immediate Cause (Final disease or condition		67 -	-	-1 - P				Onset and Death
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- -	the deay the a	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregi 9⊟ Unkn	nant at time of nown	death 5	Other (specify)				,
<u>.</u>	hat the	Ph	Part II. Other significant conditio	_ ns contributing to d	leath but not re	sulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contribute	e to the cause of death?
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ě	as so or	Completed	disease, Hy	percho	lester	olics	W, 50	ut	24a. Was ar autops perform	y prior	autopsy findings available to completion of cause of
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Vital	ysiclan: The la is certificete ha director, pege 2	Be	25. Was case referred to medical examiner?	Hospital:		1	ont 3 DDA Oth	or	ath Check only one		
5	Phys this aldii	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date		ER/Outpati 28b. Time	GIIL 3CI DDA	4 🗆 Nursing i	Home 5 Reside		(pecify)
_	ding Ph h. After thi funeral	io i	1 Natural 5 ☐ Pending	(Mon	nth, Day Year)	Injury	Worl	k? Yes 2 ☐ No	20d. Describe no	w injury occurred	
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UIVISION	or At Bitter d Direct in by	Certification:	4 Homicide determi	ned 209. Place	ling, etc. (Spec	eify)	street, factory, office		City or Town		Harar Houle Namber,
\	Hospital or Attending Physician: 24 hours after death 5 Funeral Director: After this certified stely filled in by the funeral director, i		29a. Certifier 1 Certifying	g Physician: To the	e best of my kr	eh epbelwor	ath occurred at the tin	ne, date and plac	e, and due to the ca	use(s) and manner	as stated.
)	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medicai		xaminer: On the b			investigation, in my o				
	To the 2 within 2 To the 3 complet	Me	29b. Signature and title of certifier				29c. License	e number	29	d. Date signed (Mo	onth, Day, Year)
			8000	M.D.			1	17202		11/13/2	1206
)											
)	1		30. Name and address of person v		se of death (Ite	m 23a) (Type		1202			
•	le			who completed cau			a, Print)	2	ori in	70. 219	27.
	1	tę	C1-04: C	who completed cau			e, Print)	BALTIM	ORE M	D. 2.12.	27

State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) [□], 2008 4:30 PM **Physician** November Anne Riddle Hilken /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Maplewood Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 10/096/27419133 Birthplace (State or Foreign IL Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 93 Yrs. Director 216-46-4772 Usual Residence of Decedent with the Maryland 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show ir then "natural", or items 23a or 28e-f shov 1 XYes 2 □ No Bethesda MD Montgomery Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number IISA 20814-9707 Old Georgetown Rd #3202 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. e filed within 72 hours after It Hygiene.

Other then "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo SpecifyWhite Specify þ 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry
At Home 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked oth, any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Elisabeth Shepherd Louis W. Riddle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11710 Old Georgetown Rd #802 Rockville, MD 20852-19a. Informant's Name/Relationship (Type, Print) Henry Hilken/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov 11 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2006 Chesapeake Crematory 21. Signature of Funeral Service Licensee PS1358 Rapportunerator Eactremation Services Silver Spring, Maryland 20910-933 Gist Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Cancer, Unknown Primary **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. ettending physician Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical 28. Place of Death (Check only one) Be Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending 1 □ Yes 2 □ No death. investigation s after death 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26259 11/10/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Kaufman 8218 Wisconsin Ave. #103 Bethesda, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 5 2006 market Registrar

ician	Registrar 1. Decedent's Name (First, Middle,	Last)	Ce	rtificate of	Deam	2. Date of Deat	ng. Ne. U	16	3. Time of Dea
Ciaii	Alice I Hurley					Month Novembe	Day	Year 006	6:50 AN
dical	4a. Facility Name (If not institution,	give street and number)		4b. City. Town, o	r Location of Death		4c. County		
niner	Mariner Health				Baltimore		Baltin	nore	City
	5. Social Security Number 6	S. Sex 7. Age	(In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			place (State or Fo.
al or	220-03-9343	1 M 25 F	85 Yrs.	Months Days	Hours Min.	04/03/1	.921 N	1D Cour	ntry)
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Li
৳	MD Baltim	ore City	Baltimore	e					1 ☐ Yes 215
ect	10e, Street and Number			10f. Zip Code		11	Og. Citizen of W	/hat Cour	ntry?
Funeral Director	4216 Raymar Ave			21206		1	JSA		•
Jera	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Spanic Origin? (Spanic Origin?)	ecify Yes or No-			an Indian,
교	1⊠Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2 ☐ No			etr.	Hican, etc.)		k, White,	
þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Yes 22 No	Sреспу:		Specify.	Blac	k
Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind of Bu		dustry
횰	Elementary/Secondary (0-12)	Coflege (1-4or 5+))		during most of work		Own Hom	е	
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Be	17. Father's Name (First, Middle, La Ernest Curtis	ist)			18. Mother's Name Estelle		laiden Sumam	θ)	
ပို									
	19a. Informant's Name/Relationship Nancy Curtis/Daug			-	and Number or Aura ve Baltim			State, Zip	Code)
		,				_		City on Ta	Chat-
	20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	☐Removal from State	20b. Place of Disponentery, cre			NOV 14	20c. Location -	-	
	4 □Donation 5 □ Other (Spe	ecify)		el Cemete			Baltimor	e, Ma	ryrand
	21. Signature of Funeral Service Lie	R-11. W	1111/5/		ss of Facility and Funeral Pastures I			Mars	basla
	23a Part Fater the disease or o	omplications that caused the	3,11-					Mal	Approximate
	23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	I There are being the second			9,000,00	n toophatory and			Interval Betwee Onset and Deat
	disease or condition resulting in death)	a. Dement							
			consequence of):	2001	3			5	
_	Sequentially list conditions,		consequence of):	acreur	na			-	
- ju	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interested ease)	200 (0, 0)	consequence on.						
Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):					-	
calE									
edic		d						-	
× ×	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date	of delive	-
Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)			Mon		Day Year
18	1 ☐ Yes 2 XNo 9 ☐ Unknown	9□ Unknown							
-	Part II. Other significant conditions	s contributing to death but	not resulting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use contri	bute to th	e cause of death
/Ph						1 <u> </u>	s 2 No	3 🔲 Prob	abiy 4 ⊠Unkr
Ď						24a. Was an	24h W	lasa auta	any findings ave
þ								nor to cor	psy findings avai appletion of cause
Ď						autopsy	red? de		
Completed by						autopsy perform 1 Yes 2	ANo 1	Yes	2 L No
Be Completed by	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death	autopsy perform 1 Yes 2	DANo 1	☐Yes	
To Be Completed by	examiner?	Hospital: 1 ☐ Inpatient			er: 4 Nursing Ho	autopsy perform 1 Yes 2 1 Check only one	ed? de 1 ANo 1 nce 6 □Othe	□ Yes r <i>(Specif</i>)	
To Be Completed by	examiner? 1	28a. Date of Injury (Month, Day)	28b. Time o	f 28c. Injun	er: 4 Nursing Hor	autopsy perform 1 Yes 2	ed? de 1 ANo 1 nce 6 □Othe	□ Yes r <i>(Specif</i>)	
To Be Completed by	examiner? 1 Yes 2 No 27 Magner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could no	28a. Date of Injury (Month, Day)	Year) 28b. Time o	f 28c. Injun Word	or: 4 Nursing Holy at K? Yes 2 No	autopsy perform 1 Yes 2 1 Check only one me 5 Resider 28d. Describe hor	led? di No 1 nce 6 □Othe w injury occurre	☐ Yes r (<i>Specif</i> y	')
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Certification: To Be Completed by	examiner? 1	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	y - At home, farm, ste (Specify) my knowledge, deat	f 28c. Injun Work M 1 reet, factory, office	er: 4 Nursing Hol y at x? Yes 2 No	autopsysperform Yes 2 Check only one	ed? dic No 1 1 1 1 1 1 1 1 1 1	Yes r (Specify ind	/) I Route Number.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manufand / Department of Health and Mental Hydiene

			For Amend item#19a, perFH, Col, 11/27 Registrar	Certificate of Death	Reg. No	2006 35114
	Physici		Decedent's Name (First, Middle, Last) M (LRL)	nes	2. Date of Death Month Da	Y 2006 9:45 P M
	/Medic Examin	-	a. Facility Name (If not institution, give street and number)	4b City, Town, or Location of Death	40	County of Death
	Funeral	T	Social Security Number 6. Sex 7. Age (Ih yrs. Jas	Months Days Hours Min.	B. Date of Birth (Month, Day, Year)	
	Director	ć	Isual Residence of Decedent		an. 11,146	o pudyland
	the Marylar 28e-f show	tor	Oa. State 10b. County N/A 10c. City, 1	Saltimore		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r deeth with the Maryla ems 23s or 28s-f shore	Direc	0e. Street and Number Gorsach And	10f. Zip Code	10g. Ci	tizen of What Country?
	• = a	Funeral Director	1. Marital Status 1. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1. Never Married 2 Marned 1. Lyes 22 No	13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri	orfy Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc.
, 0036	ural', or	d by F	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 22 No Specify:	105 (Specify: OUC
215-	ithin 72 ne. nen "net Medica	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	9	lind of Business/Industry
9 br	be filed w tal Hygler d other th	Be Cor	7. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maider	Surname)
arylar	d 2 should b th and Ments (7 is marked traumatic e	ToE	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural	Route Number, City	or Town, State, Zip Code)
F. √	s 1 end 2 if Heelth ar item 27 is other trau		Oa. Method of Disposition 20b. Place	e of Disposition (Name of Da	Balto, w	di 21218 ocation - City or Town, State
	Section		1 Burial 2 Cremation 3 Removal from State 4 Donation 9 Other (Specify)	etery, crematory or other place)	106 La	usdowne, md,
Balt	permit. Page Department of Important: If any Injury of		21. Signature Theneral Service Lice Isee	22. Name and Address of Facility 27 (o Fred HIL	Ton Pasz
			23a. Part Egreythe disease, or complications that caused the death. shock or beart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease of condition resulting in death) a. Due to for as a consequent of the	nce of):		
- 1		ner	Sequentially list conditions, fany, leading to immediate ause. Enter Underlying Lause (Disease of injury	1		
NS	sate be executed physiclen and the burial-transit	Examiner	Cause (Disease or injury hat initiated events esulting in death) Last c. Due to (or as a consequent content of the content of	nce of):		
68760	ficate be physicle is the bu	edical	d			
Box (ath certii ettending for use a	lan/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of deal	eath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
	at the de d by the eteched	Physician/M	9 Unknown 9 Unknown		22a Did tabassa	use contribute to the cause of death?
Division of Vital Records, P.O.	quires then signed and be d	<u>۾</u>	Part II. Other significant conditions contributing to death but not resulti	ng in the underlying cause given in Part I.	1 Yes 2	use contribute to the cause of death? 10 3 Probably 4 Unknown
Reco	ne taw re s has bee ge 2 sho	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ital	ian: Ti rificete stor, pa	Be Co	25. Was case referred to medical examiner?	26. Place of Death	1 ☐ Yes 2 ☑ No (Check only one)	o 1 □ Yes 2 □ No
<u>></u>	hysic his ce il dire	To	1 Yes 2 No Hospital: 1 Inpatient 2 □ EF		e 5 Residence	
ion o	ath. r: After t	ation;	27. Manner of Death 1	Bb. Time of Injury at Work? 28c. Injury at Up 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	8d. Describe how inju	ny occurred
Divis	al or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At hombuilding, etc. (Specify)	a, farm, street, factory, office	8f. Location (Street at City or Town, State	nd Number or Rural Route Number, e)
	To the Hospital or Attending Physician: The law requires that the death certificate be execution to A hours elter death. To the Funeral Director: After this certificate has been signed by the eltending physicien and cumpletely filled in by the funeral director, page 2 should be deteched for use as the burial-tra	ledical C	Check only one) Check only one) Check only one) Check only one)			
2442 241	To the To the	₩	29b. Signature and title of certifier	29c. License number		tte signed (Month, Day, Year) Vember 12 2006
	\		Name and address of person who completed cause of death (Item 2	3a) (Type, Print)	2/1/000	101
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	inaryana citrera	11/0501	74/

Registrar

NOV 1 5 2006

			1 - State of Maryland / Department	nent of Health and M cate of Death	F	Reg. No. UUD	36115
	Physici /Medic		1. Decedent's Name (First Middle, Last) Elizabeth January		2. Date of Dea	05 2006	3. Time of Death
	Examin	1	Haven Mursing & Rehab	City, Town, or Location of Death Baltimor	e	4c. County of Death	
£.	Funeral Director			Under 1 Year If Under 24 Hrs. Inths Days Hours Min.	8. Date of Birth (Month, Day Dec 13,	Year) 9. Birthp County 1939 Mary	
	r the Maryland	irector	10a. State 10b. County 10c. City, Town or Location	imore Of Zip Code		10g. Citizen of What Cour	Od. Inside City Limits 1√√ Yes 2 □ No htry?
15-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any figury or other traumatic svent, the Mexical Exatinizar must be multified a page.	leted by Funeral Director	3 Widowed 4 Divorced If Yes, Give Year or Dates:	21206 Decedent of Hispanic Origin? (Sp. specify Cuban, Mexican, Puerto res 2∑ No Specify: s Usual Occupation of work done during most of work (To Tuse retired)	unk	USA 14. Race - Americ Black, White, Specify: Whi 16b. Kind of Business/Inc	etc. te
Maryland 21215-0036	d be filed withir ental Hygiene. ted other than c svent, Itte M.	Be Completed	17. Father's Name (First, Middle, Last)		e (First, Middle,	Maiden Surname)	unk
	l and 2 should lealth and Me im 27 is mark her traumati	To	19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) Haven Nursing Home 19b. Mailing Ac 3939 Pe	Idress (Street and Number or Run Inhurst Avenue B			
Baltimore,	mit. Pages 1 bartment of H bortant: If ite injury or ot		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state	me and Address of Facility te Anatomy Board			
	Physician /Medical Examiner	icai Examiner	Bal: 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Bal: Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	timore, MD 2120	01 or respiratory arr		Approximate Interval Between Onset and Death
.O. Box 687	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medic		opic pregnancy er (specify)		23d. Date of delive Month	ory Day Year
<u>a</u>	uires that to a signed by ald be detact	by	Part II. Other significant conditions contributing to death out not resulting in the unions	ying cause given in Part I.		bacco use contribute to the	
al Records,	The ate h	Completed		110000		sy prior to cor med? death? 2. No 1 ☐ Yes	psy findings available inpletion of cause of
Division of Vital	Attending Physic death. sctor: After this by the funeral di	Certification: To Be	25. Was case referred to medical examiner? 1	28c. Injury at Work? 1 Yes 2 No	me 5 Residence 28d. Describe h	ence 6 Other (Specify ow injury occurred treet and Number or Rura	
ō	ospital or hours afte uneral Dir	edicai Cer					
)	To the Hospital within 24 hours a To the Funeral I completely filled	Medi	29b. Signature and title of certifier Tun M Modern MD	29c. License number 1550.	_ 2	29d. Date signed (Month,	
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print AMATUN NAME) 31. Date filed (Month, Day, Year) NOV 1 5 2006				1/4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Dorothy Jones 11 09 2006 07:55A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 237-36-2546 Director 78 10-16-1928 Rocky Mount, NC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XXNo Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 1220 Blair Mill Road Funeral 20910 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black. White, etc. 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black \$ 3 ☐ Widowed 4XX ivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) <u>Administrative</u> Howard University Hosp. 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ Elgie Battle Rowe Mary Thorpe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is many Injury or other Herbert Jones/Son 8117 Cooper Street, Alexandria, VA 22309 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State Northeastern Cemetery 11-18-06 | Rocky Mount, NC 22. Name and Address of Facility Marshall's Funeral Home re of Funeral Service Li 4217 9th St NW, Wash. DC 20011 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 YUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes XXNo ate has certificate 1□ Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, ...dl or Ah. nurs after deah. nl Director: Ah. in by the fir To the Hospital within 24 hours a To the Funeral Hospital

State Registrar

Darcie M. Hammer

🛮 🛣 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) 11-15-2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10km

and manner stated.

7600 Carroll Avenue, Takoma Park, MD 20912

31. Date filed (Month, Day, Year) 2006

29a, Certifier

one)

(Check only

29b. Signature and title of certifier

KAG

Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23e or 28a-f show

Physic /Med Exam

Baltimore, Maryland 21215-0036

	1 - State Registrar		State of W	arytanu /	•	tificate of	Health and N Death		g. No.	106	3511
	1. Decedent's Nam Ella	ne (First, Middle, Las	Mae			Johnson	n	2. Date of Death Month March 1	n Day	. Year	3. Time of Death 11:24 A
ŀ	4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of Death	·		ty of Death	11.27 A
		line Road				Haleth			Balt	imore	County
	5. Social Security N 212-05-		x 7. Ag □ M 2 1	e (In yrs. last b 92	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 09-12-	Ye <i>ar)</i> 1913	9. Birthp Cour	olace (State or Forei ntry) Md.
-	Usual Residence o	f Decedent 10b. County		10c. City, To	own or Loc	ation				1	10d. Inside City Limi
	Md.	,	LTIMORE		aleth						1 ☐ Yes 2 🔀 N
-	10e. Street and Nu	L				10f. Zip Code		10	g. Citizen of	What Cour	ntry?
	4313 A	Arline Ave	nue			212	227		US	SA	•
	11. Marital Status	ried 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 X		lf .	Yes, specify Cut	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	Bla	ce - Americ ack, White,	etc.
١	3 Widowed	4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2[X]No	Specify:		Specia	fy: E	Black
	(Spec	15. Decedent's Edicify only highest grad	ucation de <i>completed)</i> College (1-4or 5		(Give k	ent's Usual Occu ind of work done O NOT use retire	a during most of work	king	6b. Kind of E	Business/In	dustry
	5th grad	de			Hous	ekeeping	g		St. A	gnes	Hospital
	17. Father's Name Lewis	(First, Middle, Last)	Bap	tist			18. Mother's Nam	e (First, Middle, M		_{me)} Baskir	ns
		ame/Relationship (T	ype, Print) B rot				st Avenue,				Code) 215
		Cremation 3 🗆		1		ition (Name of atory or other pla	1		Oc. Location		
1		5 Other (Specify		Garr		Forest	ver' II-	-17–06	Owings		ls, Md.
	21. Signature of FL	uneral Service Licens	iee				and of Capilles 2	. 1 - 77			
+	N	ladys	War	nen			North Ave.	March F.H ., Baltim			21202
1	23a. Part1. Enter t shock, or hea	the disease, or comp art failure. List only o	ne cause on each li	ne.	1 o not ente	101 E. I	North Ave.	or respiratory arre	ore, M		Approximate Interval Between
	23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	artfailure. Listonfy o (Final on	a. No on	ne.	o not ente	101 E. I	North Ave.	or respiratory arre	ore, M	id. 2	Approximate
	shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List only o (Final on	a. No Mo	no. atomic	o not ente	101 E. I	North Ave.	or respiratory arre	ore, M	id. 2	Approximate Interval Between
	shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list contracts of the cause. Enter Under	on difficults and the second of the second o	a. No OM Due to (or as	no. atomic	o not ente	101 E. I	North Ave.	or respiratory arre	ore, M	id. 2	Approximate Interval Between
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

March 2, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 31. Date filed (Month, Day, Year)

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** James Lena 10:30a 09 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Longgreen 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 X F 215-56-4746 82 Director 03-01-1924 Ala. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Baltimore NA Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21218 401 E. 25th Street Apt. 6-G Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A Various Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tom Irene Williams Green ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 528 E. 22nd Street Sister Jeanne Barasha-St. Ann's Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest VA Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼ Burial 2 Cremation 3 Removal from State 11/15/2006 MD Owings Mills 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East lad 1101 E. North Ave., Baltimore, Md. 21202 ans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-tra as a consequence of): Box 68760, aftending physician Physician/Medical the. use as IF FEMALE It yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 mon Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 D⊌nknown has been Were autopsy tindings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy certificate 1□ Yes Physician: After this certification funeral director, 25. Was case referred to ical examiner? 26. Place of Death (Check only one) Be Other: 4 Natural Home 5 Residence 6 Other (Specify) 1 🗆 Yes 3□ DOA Certification: To 1 Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending tural 5 Pending investigation Injury Jospital C.
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7 meral Director: After 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aff
To the Funeral D
Completely filled in 29a. Certifier 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Hame and add

31. Date filed (Mo.

n. Day,

DHMH 17 Rev 1/2001

eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (1) State Amend item#20b, perFH, G861, 11/15/06 TT GREGISTREE OF Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year November 08, 2006 **Physician** oseph 14:43PM osemaru /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hospital NA Boin Secours If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🗷 F 60 10.08.1946 229.68.1313 Director Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f ahow avent, the Medical Examinar must be notified at 1 ØYes 2 No Directo MD NIA BALTIMORE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ¥ STREET POPLAR GRONE 402 21223 USA death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 250 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No lf Yes, Give Year or Dates: à 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene. ant: if item 27 is marked other ther PROBATION AGENT STATE OF MD 12 TH GRADE YRS 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be SARAH R. PHILLIP REED ANDERSON NORTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SON) SEAN JOSEPH 402 POPLAR GROVE ST. BAUD MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 11/14/2006 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages I Department of H Important: if its any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MU GREENMOUNT 21. Signature of Funeral Service Licenses 22. Name and Address of VAUGHN C. GR 5151 BALTO. N GREENE FUNERAL O. NATU PIKE, BALTO. aughn Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocondraf Inferction Physician aute Probable /Medical Due to (or as a consequence of) Examiner Croncry Drsease On terry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): physicien Box 68760 Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Year ò Day 4☐ Pregnant at time of death 5 Cher (specify) o. 9☐ Unknown ۵. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à page 2 should be Dependent Dialsetes Mill 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypitensian 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 No 1 Inpatient 2 XI R/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation the within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062183

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2006

0

30. Name and address of person who completed cause of death them 23a) (Type, Print) Marganita B- Jovel 2000 west galterore Street - Baltware, MD 21223

32 Registrar's Signature

NOJEMBE 8, 2006.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 36120 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death /Month Year **Physician** November 7:50P M 2006 Kerson /Medical Emily Ba 4c. County of Death Facility Name (If not institution, give street and number) Examiner oita Maryland HIMORE (IT) lonera 8. Date of Birth (Month, Day, Y 08 15 5. Social Security Number Age (In yrs. last birthday If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Year) Hours 1 ☐ M 2 🔀 F Yrs. 227-26-0459 96 10 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-fehov ages 1 and 2 should be filed within 72 hours after deeth with the Maryla nt of Health and Mental Hygiene.

I: if Item 27 is marked other then "netural", or items 23a or 28s-f show or other treumatic event, the Medical Examinant must be notified at 1 Tyres 2 No Directo MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U . S . A .

14. Race - American Indian,
Black, White, etc. Completed by Funeral 2132 North Smallwood Street 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No Specify: Black If Yes, Give Year or Dates: Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Lincoln Memorial Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Nurse Assistant Nursing ma 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be ၉ Henry Turner Chaney Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Della Washington-Daughter 4800 Yellowwood Ave, Baltimore, 21209 more, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages:
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once. Mulial 2 Cremation 3 Removal from State Arbutus Memorial 11/18/06 4 ☐ Donation 5 ☐ Other (Specify) Arbutus, 21. Signature of Funeral Service Licenses March F/H West 4300 Wabash Ave, cela Baltimore, 21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The lew requires that the death certificate be executed burial-transil P.O. Box 68760, Completed by Physician/Medical use es the IF FEMALE: 23c. If yes, outcome of pregnancy
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Director: After this certification by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

7

State Registrar

DHMH 17 Rev 1/2001

30 Name and address of person

31. Date filed (Month, Day,

of death (Item 23a) (Type, Print)

32. Registrar's Signature

			For State Registrar	State of Maryland	d / Depa <i>Cer</i>	rtment of H tificate of L	ealth and M Death	1ental Hyg F	gien 2 0 0 6	36121
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×	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Ψ.	IF FEMALE:	23c. If yes, outcome of pregnan	cv	-			23d. Date of d	eliven
DOX	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months?	1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)			Month	Day Year
j.	the d	ysic	1 Yes 2 No 9 Unknown	9□ Unknown						
ŗ	that led b deta		Part II. Other significant conditions co				on in Part I.	23e. Did to	bacco use contribute	to the cause of death?
2	quires n sign	d by	Breast Conc	en, Derne	ente	æ		1 🗆 Y	es 2⊡No 3⊡1	Probably 4 Unknown
ecords,	s bee	Completed						24a. Was a	n 24b. Were	autopsy lindings available
	The la	mo						autops perfori	med2 death?	completion of cause of
V II d		a)	25. Was case referred to medical				26. Place of Death			
		To B	examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3☐ DOA Othe	or: 4 Nursing Ho	me 5 Reside	ence 6 Other (Sp	ecify)
5	ng Ph fter th neral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe ho	ow injury occurred	
VISIOU	endir eath. or: Al	catic	2 Accident investigation			M 1 🗆 Y	res 2□No			
ž	or Att	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)		et, lactory, office		28f. Location (St City or Town	treet and Number or I n, State)	Rural Route Number,
ב	pital	O	200 Conffice	olelen. To the best of	tadar 4 ··	annumer of each trans	a data and all a	and due to the	21122(2)	an etated
	To the Hospital or Attending Physician: within 24 hours after death. To the Suneral Director: After this certific completely filled in by the funeral director,	edical		sician: To the best of my know ner: On the basis of examination and manner stated.						
	o the ithin (o the omple	Med	29h Signature and title of certifier			29c. License	number	2	9d. Date signed (Mor	nth, Day, Year)
	⊢≯⊢ŏ		1 M hather	hely u	6	112	5205		Vovenbe	18,2006
		i	30. Name and address of person who co	ompleted cause death (Item	23a) (Tvpe. F	Print) a	C . A	2.		
			30. Name and address of person who co	56mc 670	IN-	Charle.	st. Ho	elts - w	14 2020	عراد
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signatu						
	Registr		NOV 1 5 200	5 Marian As	Bose	chies				

	1	For State Registrar	State of Man				ealth and Death	d Mental H	lygiene Reg. No		6	3612	2
		Decedent's Name (First, Middle, La	st)					2. Date of	Death		ear	3. Time of Dea	
nysicia Medica	_	Annie Elee	se Kerby					Nov 2	, 200	6 '	941	12:34P	М
nine		4a. Facility Name (If not institution, giv			4b. City		Location of De	ath	1	. County of I		1-	
			ryland Hosp		If Linds	Clin or 1 Year	Iton If Under 24 H	rs. 8. Date of		rince			
ı		5. Social Security Number 6. S	M 2 F 8	n yrs. last birthday) — Yrs.	Months		Hours M	in. (Month.	Day, Year))	Coun	lace (State or Foi try) ch Carol	
		243 22 7174 Usual Residence of Decedent	AA O	J	1			Dec 8	, 192	.0	NOL	II Caror	IIIa
	. [10a. State 10b. County		0c. City, Town or Lo		** . 7 7					10	Od. Inside City Lin	
	cto	Maryland Prince (George's	Ten		Hills	3					1 Yes 2	.181O
	Director	10e. Street and Number 7200 Waldran A	170			ip Code 20748	3			tizen of Wha		,	
	a a		12. Was Decedent Eve	w in 11 C 12				(Specify Yes or	-	ted S			
	ᆵ	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		If Yes, spe	ecify Cuba	n, Mexican, Pu Specify:	erto Rican, etc.)	No	Black, \	White, 6		
•	Completed by	3 Nidowed 4 Divorced 15. Decedent's E	Year or Dates:	16a. Dece			ation		16b K	(ind of Busin			
	oiete	(Specify only highest gra	ide completed)	(Give	kind of w	ork done d	lurina most of v	vorking	100.1	and or busin	033/110	iustry	
ı	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Ноте	emake	r				own Ho	me		
П	a)	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Mid	dle, Maider	Sumame)			
	ToB	Junius Lucas					Mary S	Sutton					
I,		19a. Informant's Name/Relationship (** .					Rural Route Nui					
		Robert Best (So						d, Brand					
÷		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cre	osition (Na matory or	ame of other plac	Nov 8,	2006	20c. L	ocation - City	y or To	wn, State	
		4 Donation 5 Other (Special		Maryland					_			Marylan	d
		21. Signature of Funeral Service Lice	Moo2					ee Funer Koad, Cl		41775		633 01d 735	
n d		23a. Firt1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. ACUTE Due to (or as a c	MYOCI			-00					Approximate Interval Between Onset and Deatl	ŀ
	Exa	S juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c		_								
1	edicai		_ d								1		
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 NNo 9 □ Unknown	23c. If yes, outcome of particles of the last of the last outcome of particles of the last outcome outcome outcom	Fetal death 3	⊒Ectopic p ⊒ Other (s				-	23d. Date of Month		ry Day Year	
	2	Part II. Other significant conditions of	contributing to death but r	ot resulting in the u	ınderlying	cause give	en in Part I.				te to th	e cause of death	
	Completed							24a. W	tasan	24b. Wer	e autop	osy findings avail	able
	E							- pe 1 □ Ye	itopsy erformed? s 2⅓No	deat	h?	2 No	J.
- 1	0	25. Was case referred to medical					26. Place of D	eath Check on		1000			
	0 0	examiner? 1 ☐ res 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 D	Othe Othe	er: 4 🗆 Nursing	Home 5□R	esidence	6 □Other (Specify)	
		27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time o		28c. Injury Work		28d. Descrit	oe how inju	ry occurred			
	Certification;	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	Blace of Injune	- At home, farm, st Specify)	M reet, facto		Yes 2 □No		n (Street ar Town, State		r Rurai	Route Number.	
	Medicai C		ysician: To the best of miner: On the basis of ex	amination and/or in									
1 3	ĕ	29b. Signature and title of certifier	and manner stated		29	c. License	number		29d. Da	ite signed (N	fonth, L	Day, Year)	
	≥												
	2					DUA	314		Nov	EMRI	70	3 2000	-
		30. Name a Laddress of person who	completed cause of deat	h (Item 23a) (Type, 3 SU, CRAI	Deinel		324					3,2006	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Рм renned 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Ichrist If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours Min. 1 ☑ M 2 ☐ F Yrs. 249-07-8844 Director 10/27/1917 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 Nes 2 No Directo MD Kaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/21 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give 1 Never Married 2 Mamed Specify: Black 1 ☐ Yes 2 No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates is marked other than "natu aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NA)River Bethlehem permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other th any injury or other traumatic event, th once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Kennedy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ္ရ 19a. Informant's Name/Relationship (Type. Print) (wife) 1944 Mosher St Battimore, MD ice of Disposition (Name of Date 200 Willie Mae Kennedy 3151 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Balthmore, MD W13/2006 22. Name and Address of Facility Yough C. Greene Fungeral Syc 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pike Baltimore, MD 51230 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Asylvan previous Due to (or as a consequence of): /Medical Examiner Due to (or as a consequence of): Pristare menin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical the attending post-IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐Unknown 1 signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy certificate 2**X** No 1 ☐ Yes or Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4X Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this (2 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Division Injury 1 🗌 Natural OCTORE 7 2006 UN Know M 1 28e. Place of in ury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 V No I hours after death. uneral Director: A death. tall 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Nusing Nome 1944 MOSHER ST. HATIMORE M) within 24 hours a Certifying Physician: To the Best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only / 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. Charles BAI tonno warles 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CECELIA KNEIP 2006 6:45 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12661 ROUNDWOOD ROAD TIMONIUM BALTIMORE 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Year) Months Days Hours 1 □ M 2**X** 203-07-6827 87 PENNSYLVANIA Director 11-21-1918 Usual Residence of Decedent with the Maryland 10a, State 10c. City. Town or Location 10d. Inside City Limits 28a-f show пs 23a or 28a-f shov must be notified at MD. BALTIMORE TIMONIUM Director 1 ☐ Yes 2 💢 💢 o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ROUNDWOOD 12661 ROAD, RM.413 21093 U. S. A. death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. Specify: WHITE ş ₩Widowed 4 Divorced 'natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 YEARS DEPARTMENT STORE College (1-4or 5+) MANAGER n and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JOSEPH** LIPINSKI, SR. STELLA WICHNOWSKA ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a Important: If Item 27 is any Injury or other tra once. 2124 FOREST RIDGE ROAD, TIMONIUM, MARYLAND, 21093 LINDA C.HEIKKINEN (DAUGHTER) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State PARADISE MENNONITE CEM.11-14-2006 LANCASTER, PENNSYLVANIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1050 YORK ROAD 4. Ruth (R.G.RUTH) RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, n each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying causes Disease of injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injurithat initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ate 2/X/No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes XX No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After XX Natural 2 ☐ Accident 5 Pending investigation (Month, Day Year) within 24 hours after deau... To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMBER 10, 2006

State Registrar 31. Date filed (Month, Day, Year)

1 5 2006

DHMH 17 Rev 1/2001

MONIUM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Popistrar's Signatur

			For State	State of Maryland / Department o		tal Hygiene	2006	36125
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of		Reg. No.	_000	3. Time of Death
я	Physicia		Indilliam G	100 Tr	N	Month Day		5 45 A M
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number) 4b. City, Tow	n, or Location of Death		County of Death	J 75 A
			SAINT AGNE	S HOSPITAL BA	LTIMORE		NA	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Yrs. Months Da	ear If Under 24 Hrs. 8. Days Hours Min.	Date of Birth Month, Day, Year)	9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	60 115.		V. 5, 19	tb 1410	iryland
	yland		10a. State 10b. County	10c. City, Town or Location			1	0d. Inside City Limits
	Ba-f	ctor	Md. N/A	Baltimor	e			1 PYes 2 □ No
	vith th	Dire	10e. Street and Number	10f. Zip Coo	10 D A	10g. Citi	izen of What Coun	ntry?
	eath v	by Funeral Director	11. Marital Status	N. Was Decedent Ever in U.S. 13. Was Decedent	of Hispanic Origin? (Specify	Yes or No-	14. Race - Americ	ean Indian
ധ	or Item	Fun	1 Never Married 2 Married	Armed Forces? If Yes, specify (Cuban, Mexican, Puerto Ricar	n, etc.)	Black, White,	
ğ	filed within 72 hours after death with the Maryland Hygiene. sther then "naturel", or Iteme 23e or 28e-f ehow ent, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Ves, Give Year or Dates: 1 ☐ Yes 2 🕅	No Specify:		Specify: B	acK
<u>5</u>	"natu	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. Decedent's Usual Oc completed) (Give kind of work of life. DO NOT use re	one during most of working	16b. Ki	ind of Business/Ind	dustry
21215-0036	withir iene.	дшс	Elementary/Secondary (0-12)	College (1-4or 5+)	CH Office	or p	dice.	hont
<u>5</u>	Hygin other	Be C	17. Father's Name (First, Middle, Last)	Aurilla	8. Mother's Name (First	st, Middle, Maiden	Sumame)	DEPT.
Maryland	should be nd Mental marked c	To E	William G.	ee Sr	Marie V	ivian	Greene	Lee
Nar	2 sho		19a. Informant's Name/Relationship (Typ	NTI BIEIL FAIR II	reet and Number or Rural Roo	ute Number, City o	r Town, State, Zip	Code)
	1 and Health em 27 ther tr		103. Barbara 20a. Method of Disposition	20b. Place of Disposition (Name of	or WOOD A	Ve Ba	ocation - City or To	1, 2/201
nor	Pages nent of I int: If its iry or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State cernetery, crematory or other	place) 11/50/5	006 Du	Lace A	1:11 MA
Baltimore,	그런근를		21. Signature of Funeral Service License		1621		11195 1	1115,1414
Ä	Department of the control of the con		* Choseph	L. Kuss 20seph	L. Kuss Fun	eral Mo	me, P.A.	1216
			23a. Part 1. Enter the disease, or complice shock or heart failure. List only one	ations that caused the death. Do not enter the mode of cause on each line.	dying, such as cardiac or res	piratory arrest,		Approximate Interval Between
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	SEPTIC SHO	CK			Onset and Death
	Examiner		1	Due to (or as a consequence of):	NECTIO		1	2 1 1 2 2
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	INTECTIO	14		JYA75
	od nd transit	Examiner	Cause (Disease or injury that initiated events					
60,	cate be executed physician and the burial-transit	E X	resulting in death) Last	Due to (or as a consequence of):				
68760,		edical	d.					
Вох	death certifica le attending ph ad for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregn.			23d. Date of delive	ery
B	~ w	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal death 3 Ectopic pregn. 4 Pregnant at time of death 5 Other (specify 9 Unknown			Month	Day Year
P. 0.	that the death cer ed by the attendir detached for use	Phy	9 Unknown	ributing to death but not resulting in the underlying cause	e green in Part I	23e. Did tobacco u	use contribute to th	an cause of death?
Division of Vital Records,	uires tha signed I d be det	d by	HYPERTENSIO		•	1 Tes 2		
O	sw require s been sig s should b	ojete	SEIZURF CHR	ONIC RENAL FAILUR		24a. Was an	24b. Were auto	psy findings available
æ	The la	Completed	,	TERY DISEASE		autopsy performed? 1□ Yes 2⊠No	prior to cor death? 1 \(\text{Yes} \)	mptetion of cause of
/ita	clan: sertific setor.	Be	25. Was case referred to medical examiner?		26. Place of Death (Ch			
of	Physic this cral dir	<u>۲</u>	1 Yes 2 No	spital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ 28a. Date of Injury 28b. Time of 28c.	Other: 4 Nursing Home	5 Residence Describe how injur		y)
o	th. : After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Injury at Work?	Describe now injur	y occurred	
Visi	ar dearector	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)	fice 28f. L	ocation (Street an City or Town, State	d Number or Rura	I Route Number,
Ö	iltal or irs after ral Dia			Danding, etc. (Specify)			, 	
	Hosp 24 hou Fune Hely fi	edicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	cian: To the best of my knowledge, death occurred at the serior of the basis of examination and/or investigation, in read the proper stated.	ne time, date and place, and d my opinion, death occurred at	due to the cause(s) the time, date and	and manner as st place, and due to	tated. the cause(s)
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Med	29b. Signature and title of certifier	and manner stated.	cense number	29d. Dat	te signed (Month,	Day, Year)
			Ineletin.	RESIDENT P	20954	Na	V 08	2006
	2			pleted cause of death (Item 23a) (Type, Print)				- 0
			MUDDASSTR SA 31. Date filed (Month, Day, Year)	MA, 900 CATON AVE	NUE, BALT	IMORE,	MD 2	21229
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Freddie Clay Month Year Lewis, Sr. **Physician** Nov 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore NA HOSPITAL BALTMOR If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Months Days Min. Hours 1X M 2□ F 220-36-4260 Director 04-10-1941 S.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 XYes 2 No Director Md. NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 7014 Arion Avenue 21234 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√D Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural" or item any Injury or other traumatic. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏋 No Specify Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver J.H. Broadway Services 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abraham Lewis Elizabeth Griddle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hattie Lewis Wife 7014 Arion Avenue, Baltimore, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Dulaney Valley 11-15-06 Timonium. Md. Donation 5 Other (Specify) March F.H. East re of Funeral Service Licenses 22. Name and Address of Facility Signat 1101 E. North Avenue, Baltimore, Md. 21202 t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one caus an each line. meriate Cause (Final Physician TOLYMICROBI e or condition ting in death) /Medical Due to (or as a consequence of): Examiner KESPIRA TOP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1□ Yes 2 🗖 No Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 √No 2 ER/Outpatient 3□ DOA Certification: To After this 27. Mannef of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 ☐ Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident death. filled in by the Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifiei 🕯 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, within 24 hours after death To the Funeral Director: completely the

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier rerin who completed cause of death (Item 23a) (Type, Print) Name and dd VEDERE AUE 31. Date filed (Month, Day, Year) State NOV 1 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 6. Year November 6. 2006 **Physician** 1:42PMm Lillian Ellen Landrum /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 3809 St. Barnabas Road Suitland If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Virginia 8. Date of Birth (Month, Day, Year) April 22, I 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 224-10-7192 22,1920 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examine. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Prince George's Suitland Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3809 St. Barnabas Road # T3 20746 U.S.A. Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify \$ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Fort Hamelton Hospital 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ray Johnson Brummett Birgie Lee Falner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2107 Calloway Street Temple Hills, Maryland 20748 Mildred A. Maurice (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
National Memorial Park Nov. Date 13. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Falls Church, Virginia 2006 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signatur of Funeral Service Lice 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lewsel Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner The law requires that the death certificate be executed and for use as the burial-tran Due to (or as a consequence of) attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page performed' certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Certification: To Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year)

Registrar

State

Division or Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

31. Date filed (Month, Day, Year)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** YEH - O LAN 1:50 p^M November 12, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13236 Triadelphia Road Howard Ellicott City 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 🗌 M 78 Director 215-57-0302 Feb. 1, 1928 China Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.

other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sl edical Examiner must be notified Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13236 Triadelphia Road 21042 Taiwan Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify. þ 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grade 6 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental h should be Bo-Win Lan (unknown) Yu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Eugene Chen 13236 Triadelphia Road Ellicott City, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 tment of I Department of important: If it any Injury or conce. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) West Arundel Crematory 11/14/2006 Odenton, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or con shock, or heart failure. List only Approximate Interval Between Onset and Death omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ply one cause on each line. Immediate Cause (Final **Physician** Anemia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examine death certificate be executed that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No for Month Year 4□Pregnant at time of death 5 Other (specify) P.O. 1 signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Number Completed need 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No has page 2 autopsy performed? Yes 2**X** No certificate 1∐ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home SX Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗀 Inpatient After this 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Attending 1 🖾 Natural 5 Pending Injury 1☐Yes 2☐No investigation death 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō 29a. Certifier 1XX pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Physician D0056950 November 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8094 Edwin Raynor Blvd., Suite A, Pasadena, Maryland 21122 Nnaemeka Agajelu, M.D. 31. Date filed (Month Day, Year) 32. Registrar's Signature State Registrar

08643 niel J. Lochmar		Please Type or State of Maryland / Depa	artment c	of Health and		lygiene	20	06 3612
Physician	/ /	egistrar . Decedent's Name (First, Middle,Last)	rtificate c	of Death	-	2. Date of Deat	eg. No. h	3. Time of Death
edical Examine		Daniel J. Lockman a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Deat	Month November	13, 2006 4c. County of E	0940 hrs Death
/ Funeral		Baltimore Washington Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday)	Glen Burnie		s. 8. Date of Birt		9. Birthplace (State or
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Maryland 28a-f show any d at once.	Ī	Md. Anne Arundel Pas	, Town or Loca adena					10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once	Ulrector	335 North Ferry Point Road		10f. Zip Code 21122		10	ng. Citizen of What USA	Country?
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36 hin 72 hours a than "natura dical Examira had	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +4		ent's Usual Occupat most of working life,			16b. Kind of Busin	•
21215-0036 and be filed within 7 Mental Hygiene marked other than c event, the Medica	<u>a</u> [7. Father's Name (First, Middle, Last) Charles Lockman	<u> </u>		Ruth	Hock	Maiden Surname)	
MD 21 nd 2 should alth and Me m 27 is ma aumatic er	2	9a Informant's Name/Relationship (Type, Print) Mrs. Donna Lockman/ Wife	19b. Maili 335	North Fer	ry Poin	Rural Route Num t Rd. Pa	sadena, M	State, Zip Code) 1d. 21122
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours af postarment of Health and Mental Hygiene Important: If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examin		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or d	le Cemete	ry 11	Date -18-06	Delta,	
		21. Signature of Funeral Service Licensee		Name and Address Ruck Tow 1050 Yor	ison Fun k Rd. T	eral Hom owson, M	e, Inc. d. 21204	
Physician /Medical Examiner		23a. Part I. Enter the disease, or complete from that caused the death failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of the condition resulting in death)	c cardio			or respiratory arre	est, shock, or heart	Approximate Interva Between Onset and Death
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and and		d						
Box 68760, e death certificate be ex the attending physician ed for use as the burial		F FEMALE: 3b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 12 months?	gnancy 2 F	g862, 12/7,	/06 TT Ectopic pregr	nancy	23d. Date of de Month	livery Day Year
Box (e death ce the attend the attend ned for use	ysici	1 Yes 2 No 9 Unknown 9 Unknown	eath 5 (Other (Specify)				
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vision of Vital Records, P.O. Box 68760, for Attending Physician: The law requires that the death certificate be expired eath in the confine that he been signed by the attending physician in by the funeral director, page 2 should be detached for use as the burial	Completed					24a Wasa autop perfor 1 Y Yes	sy price dea	re autopsy findings available to completion of cause of ath? Yes 2 No
Vital ysician: this certif	o Be	25. Was case referred to medical examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V	ER/Outpatie		of Death (Chec		Residence 6	Other:
ion of Vi tending Physi eath or: After this the funeral dir		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time o		ry at Work?	28d. Describe l	now injury occurred	
led in graph of a second in the second in th	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At h	nome, farm, str			28f. Location (\$ or Town, \$		or Rural Route Number, City
	Medical C	29a Certifier 1 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination a						
To the within To the comple	Mec	29b. Signature and title of certifier Adular		29c. Licens O.C.I	e number			(Month, Day, Year)
		Name and address of person who completed cause of death (Iten Carol Allan, MD Assistant Medical Examiner		Street, Baltim	ore, MD 212	01		
Sta Registr	_	31 Date filed (Month, Day, Year) NOV 1 5 2006 Registrar's Signal	ure	A)				

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 13, 2006 Medical Examiner 1600 hrs Joseph W. Marquardt, 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Caroline Preston 4825 Everlea Court If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreian Months Days Hours Directo Country) Maryland 218-34-8471 1 X M 2 F 1939 67 May 24 Usual Residence of Decedent 10a. State 10d. Inside City Limits Any. 10c. City. Town or Location 1 Yes 2 X No or 28a-f show MD items 23a or 28a-f shoust be notified at once, Caroline Preston hours after death with the Maryland Director 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 4825 Bethlem Road 21655 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, must be Armed Forces? White etc. 1 Never Married 2 Married X Yes es, Give Year ö Specify White Yes 2 X No specify Widowed 4 X Divorced (Pages 1 and 2 should be filed within 72 hours after tment of Health and Mental Hygiene rtant: If item 27 is marked other than "natural", ð 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Plumbing, Heating & Baltimore, MD 21215-0036 11 Electrical Contracting Business Owner 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) t t æ Frederick W. Marquardt Rita Jurceka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gary Marquardt, 103 High Street 0xford MD20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 XCremation 3 Removal from State Metro Crematory, Inc. 11/15/06 Donation 5 Other Specify Baltimore, MD 21. Signature of Funeral Service Licensee George MacNab 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road Pasadena, MD Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Thermal Injuries complicating Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of: if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last pue Physician/Medical UNPENDED AMENDED Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ğ 1 Yes 2 No 3 Probably 4 V Unknown Chronic Obstructive Pulmonary Disease Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed' Yes 2 1 🗸 Yes No certificate 25. Was case referred to medica 26. Place of Death (Check only one) To the Hospital or Attending Physician: Division of Vital Be examiner? Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 this 1 Yes ဥ No After t 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Nov 13, 2006 Victim of car fire 1 1545 hrs Natural 5 Pending 1 Yes 2 V No Director: d in by the f 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) 4825 Everlea Ct, Preston, MD 24 hours af
Funeral D
etely filled i (Specify) Local Street Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License numbei 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E November 14, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) 32. Registrar's Signature State

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Funeral

Director

in "naturel", or items 23e or 28e-f show Medical Examiner must be notified at

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nd 2 sho eith end N 27 is me r treums		19a. Informant's Name/Relationship (Type, Print) (daughter)	19	b. Mailing Addi 241 Me	ress (S dwi (treet and Number or CK Garth 1:	Rural R lest	oute Numb , Cato
permit. Peges 1 and 2 should be filed with Department of Heelth and Mentel Hyglen important; if item 27 is marked other thany injury or other treumatic event, the once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	memoval from State		of Disposition (ery, crematory Cremat			Nov	Date 7. 17
permit. Depertr Importu		21. Signature of Funeral Service Lice	see				ddress of Facility Ountain R	Stal	lings
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To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 burns after death. To the Funeret Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funerel director, page 2 should be deteched for use as the burlei-trensit	Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	e to (or as a	consequence consequence	of):	e given in Part I.		23b. Did
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nding Physath. r: After this e funerel d	edical Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yo	2 □ ER/C ear) 28b.	Time of Injury	DOA 28c.	Other: 4 → Nursing Injury at Work? 1 □ Yes 2 □ No		5 🗀 Resid
To the Hospital or Attending Physician: The lew requires thet the death certificete be ex within 24 hours efter death. To the Funerel Director: After this certificete hes been signed by the ettending physicien is completely filled in by the funerel director, page 2 should be deteched for use es the burlei	Certific	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (3	- At home, i Specify)	farm, street, fac	tory, of	fice	28f.	Location (S City or Tox
To the Hospital within 24 hours To the Funerel completely filled	edical (29a. Certifier (Check only one)	yaiclan: To the best of m niner: On the basis of ex and manner stated	amination a	ge, death occurr nd/or investigat	ed at the	ne time, date and pla my opinion, death o	ace, and ocurred a	due to the at the time,
Volthi To #	Σ	29b. Signature and title of certifier				29c. Li	cense number		
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Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician November 12,2006 2:05 PM Mary Ellen Merkel /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Catonsville Baltimore Ridgeway Manor H Under 1 Year If Under 24 Hrs. Months Days Hours Min. 3 Date of Birth (Month, Day, Year) 341 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 ☐ M 2 🕽 F 212-40-2841 65 Yrs. MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 241 Medwick Garth West 21228 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White þ Specify: 3 ☐ Widowed 4 ☑ Divorced pieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Maiden Sumame) Regan er, City or Town, State, Zip Code) ONSVIIIe, MD 21228 20c. Location - City or Town, State Baltimore, Maryland Funeral Home, P.A. dena, MD 21122 Approximate Interval Between Onset and Death 1+ Honthe tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 € tinknown 24b. Were autopsy findings available prior to completion of cause of death? an autopsy med? res 2 ⊡+No 1 ☐ Yes 2 ☐ No dence 6 Other (Specify) how injury occurred Street and Number or Rural Route Number, vn, State) cause(s) and manner as stated. date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 1 Willer D14662 11-12-2006 30. Name and address-of person who completed cause of death (Item 23a) (Type, Print) Hipewer \$ 508 Gley Bring, Maryland 21061 12:telie 7310 (Lucans) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 5 2006

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene

DHMH 16 Rev 6/95

Registrar

			For State Registrar	State of Mary		artment of H rtificate of L		-	ene 2 0	06	36132
	Physicia		1. Decedent's Name (First, Middle, La John C.	Miller	Jr.			2. Date of Death Month November	Day	2006	3. Time of Death 08:35 AM
	/Medic Examin Funeral		4a. Facility Name (If not institution, giv 226 01d Magothy 5. Social Security Number 6. S	Bridge Road	yrs. last birthday)	P &	Location of Death ASadena If Under 24 Hrs.	8. Date of Birth	4c. County	ne Arı	
	Director		219-32-1590 Usual Residence of Decedent	∑ M 2□ F	70 Yrs.	Months Days	Hours Min.	Sept. 2	5 1936	Count	MD MD
	be filed within 72 hours after death with the Maryland and hydrone. dictional relatively, or feme 23s or 28s-f show dictional the motified at event, the Medical Examinant can it is notified at	Director	10a. State 10b. County Maryland Anne A 10e. Street and Number 226 Old Magothy	rundel	c. City, Town or Lo	idena 21122	10	g. Citizen of \		od. Inside City Limits 1 ☐ Yes 2 ☑ No	
020	ours after death ref; or Iteme 23 Exemir er mus	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	ispanic Origin? (Sp un, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America ck, White, e				
Mai ylailu 21213-0030	ed within 72 he giene. er than "natui ; ine Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	(Give	dent's Usual Occup. kind of work done of DO NOT use retired Administt	during most of work to ator	ing	Telecommunications		
2 2	uld be file Mental Hy rked oth tic event	To Be (17. Father's Name (First, Middle, Last, John C. Mi	ller Sr.			18. Mother's Nam Doroth	e (First, Middle, M y V.	a <i>iden Sum</i> an Barnes		
Dallinore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Menlah Hygiene. In popertrent: If item 27 is marked other than "naturel; or iteme 23a or 28a-f show any njury or other treumatic event, in a Medical Examinating manifest at one.		19a. Informant's Name/Relationship (Shirley J. Miller 20a. Method of Disposition 1 Burial 2 Gremation 3 4 Donation 5 Other (Special Signature of Funeral Service Light)	(Spouse) Removal from State (y)	226 Ob. Place of Disponsementary, crem Metro Cr	ematory or other place ematory 1 2. Name and Addres	othy Brid Nov. Inc. 20	ge Road, Date 15 06 E	Pasade Oc. Location Baltimo Js Fune	ena, M City or To Ore, M eral H	AD 21122 wm, State Maryland Horne, P.A.
0,00,	cate be executed /Medical Examiner up physicien and the butial-transit	dicai Examiner	23a. Part 1. Enter the disease, or consock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a co	nsequence of):	tal Co	ental	Canc		- 3	Approximate Interval Between Onset and Death
יס. מסי	requires that the death certifics seen signed by the ettending pt hould be detached for use as t	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,			ite of delive	ry Day Year
L	sign Sign d be	ed by PI	Part II. Other significant conditions	contributing to death but go	deat f	nderlying cause giv	en in Part I. Y 2066	23e. Did toba		tribute to th	e cause of death?
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Division of Vital necords,	ling Phye	ToB	examiner? 1 Yes 2 No 27. Manner of Death Chatural 5 Pending 2 Accident investigation		2 ER/Outpatier 28b. Time o	f 28c. Injur Wor	er: 4 Nursing H	th (Check only one ome 5 Resider 28d. Describe how	nce 6 Oth)
	tal or Attend s efter death al Director: , ed in by the f	Certification:	3 Suicide 6 Could not to determined		At home, farm, sti pecify)	reet, factory, office		28f. Location (Str City or Town,		ber or Rura	l Route Number,
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	10		38. Nam an address of per at who	completed cause of death	(Item 23a) (Type,	Print)	tal n	2) SV12	AnBu	inie!	y- 2,106 1
4	Sta Regist	ate rar	31. Date filed (Month Day, Year)	006 32 Registrar's	Signature		V) 0			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mont 13^{Day} 2006 7:30p. M Maybank Carol Elease /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Towson Gilchrist Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 □XF Months Days Min 60 Director 218-42-5592 05 06 46 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Catonsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 1211 Black Friars Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc filed within 72 hours after of Hygiene. "Attendance of Hygiene" of Heiles of 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married AMarried Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Verizon Telephone Co. Customer Service Rep. 12th grade permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If Item 27 Is marked oths any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Shannon Phillip Gerald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9544 Wesland Circle, Randallstown, Md 21133 Ronnie Maybank-Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial XIXCremation 3 ☐Removal from State Metro Crematory Inc 11/15/06 Baltimore, Md 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses March F/H West 4300 Wabash Ave, 21215 elprion Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) enal wels /Medical Due to (or as a conse), nce of) Examiner weeks Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 athereschoolie ducase 2 **X**/No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 X No 1□ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NOSCU 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) completely and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Navember 14 2006 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 Chones w 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOA Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Thomas Christopher Michaelides 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner 1829 hrs November 12, 2006 Thomas Christopher Michaelides 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 23 Kingslev Road Owings Mills **Baltimore County** 5. Social Security Number 6. Sex 7 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Maryland Months Days Hours Min Director 217-94-7097 42 Aug. 13, 196 1**X X**M 2 F Usual Residence of Decedent 'n 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XXNo or 28a-f show Baltimore Owings MI11s Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f elso tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 23 Kingsley Rd. U.S.A. 21117 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1XXNever Married 2 Married Yes 2X X No Widowed Divorced f Yes, Give Year Yes XX No specify: White Specify: 3 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Warehouse Baltimore, MD 21215-0036 12 Supply Manager 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Barbara Marie Kline John Anthony Michaelides, Sr. 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Father John Anthony Michaelides Kingsley Rd. Owings Mills, MD 21117 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemeter) 1XXBurial 2 Cremation 3 Removal from State Crematory or other place) Important: injury or oth 11/16/06 Sykesville, MD Memorial Park Donation _5 Other Specify 22. Name and Address of FacilityEckharot Funeral ape 21. Signatu of une Service Licen. 11605 Reisterstown Rd. Owings Mills, MD21117 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Retween Onset and /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last The law requires that the death certificate be executed and trans Physician/Medical attending physician or use as the burial X UNPENDED AMENDED #23a,27,perME, g862, 12/5/06 TT Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 1 🗸 Yes No 2 No To the Hospital or Attending Physician: within 24 hours after death
To the Funeral Director: After this certifi 25 Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ DOA Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes ို 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined (Specify) Homicide 29a Certifier 1 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started one) 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 13, 2006

Theodore M. King, Jr., MD. 31. Date filed (Month Day) 5 2006

ne and address of person who omp

leted ta se of death (Item 23a)

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

State

Registrar

Byron George McCleary

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 36135

		I- For State Registrar	Cert	tificate of	Death		F	€_ Reg. No.	. 0 0 (1 1011
Physicia		Decedent's Name (First, Middle,La	st)				2. Date of Dea	ath		3. Time of Death
edical Exami		Byron	George		McClea	ary	Novembe	er 11, 2006	/ear	1130 hrs
		4a. Facility Name (if not institution, gi		1	4b. City, Town, or L		ith	4c. Coun	ty of Death	
		1810 Etting Street			Baltimore					
Funeral	\Box	Social Security Number 6. S	Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24h		rth (MM/DD/YY	YY) 9. Birth Foreign	nplace (State or
Director	- 1	219-64-2075 15	(M 2 F 49	Yrs	Months Days	Hours N	06	11 57		
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MD 3 Id 2 shot Ith and n 27 is 1		Gloria McClean	ry=Mother	10	Lynvie					21215
Tore, MD 2 shount of Health and Nt. If item 27 is not not the traumatic	1	20a. Method of Disposition	20b. P	Place of Dispos	sition (Name of cerr		Date	20c. Location		
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altimore, mit Pages I ar partment of Her portant: If ite	- 1	4 Donation 5 Other Speci	,				.1/10/0	q Kanc	lalis	town, Md
Baltimore, MD 21215-00; permit Pages I and 2 should be filed with Department of Health as Montal Higtone Important: Iriem 27 is marked other injury or other traumatic event, the Met.	- 1	21. Signature of Funeral Service Lice	nsee	Ma	rch F/H	West				
	-1	23a Part I. Enter the disease, or cor	nondi	43	00 Waba	sh Ave	, Balt	imore	<u>Md</u>	21215 Approximate Interval
Physician /Medical		failure. List only one cause on	each line					irest, shock, or	neart	Between Onset and
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8760, ifficate by up physic	Me	IF FEMALE:	23c If yes, outcome of pregr	nancy	-, postal,		10000	23d Date	of delivery	
		23b. Was decedent pregnant in the past 12 months?	1 Live birth	+ Ale	etal death 3	Ectopic pre	gnancy	Month	n D	lay Year
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ital Recorician: The law 1	E							formed?	death? 1 ✓ Ye	s 2 No
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Vita ysicia his ce direc	o Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA	Other Nu	rsing Home 5	Residence	6 🗸 Other	: Scene
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Division of Vital Records, pital or Attending Physician: The law requir corra after death ceral Director. After this certificate has been stilled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 X Could n 4 Homicide determine	and in the	building					O Etti	ng Street
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To the within To the comple	Medical	29b. Signature and title of certifier	and manner stated		29c. Licens					nth, Day, Year)
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		Youlf Tour	WH, MU	20-1						
		30. Name and address of person when Pamela E. Southall, MD	Assistant Medical Exa		11 Penn Street	t Baltimore	MD 21201			
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Registrar

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			For State Registrar	State of Marytan		rtificate of			211116	36137		
18			Registrar Decedent's Name (First, Middle, Last)		001	incate of	Dealli	2. Date of Deatl	19. 140.	3. Time of Death		
	Physici		Arthur Eugene Mal	10110				Month 11	08 2006	11;00 P ^M		
197	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat					
		Ç.	Washington Advent	ist Hospital		Takoma	Park		Montgon	Montgomery		
No.	Funeral		Social Security Number 6. Security Number		last birthday)	If Under 1 Year Months Days				thplace (State or Foreign		
12	Director		243-36-2962	IM 2□F 73	Yrs.			06-02-1		nington, NC		
	and we		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits		
	Mary 1 aho	ţō	MD Montgomer	т.	akoma F	lowle				1 ☐ Yes 2 🔀 No		
	r 28a	Director	10e. Street and Number	у 12	ikoma i	10f. Zip Code		10	og. Citizen of What Co	ountry?		
	23a o	a D	7520 Maple Avenue	#703			20912		USA			
	dea	Funeral		12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decedent of l	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No-	14. Race - Ame Black, Whit			
36	or it	by Fu	1 Never Married 2 Married	1. XiYes 2 □ No If Yes, Give		1 ☐ Yes 2X No		,,	Specify: B1			
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene of other than "natural", or items 23a or 28a-f ahow ovent, I're Mydical Exam, or mush the collins a se	d b	3 ☐ Widowed 4 🛣 Divorced 15. Decedent's Edu	Year or Dates:	16a Dagge	dent's Usual Occu	nation					
7	n n	olete	(Specify only highest grad	completed)	(Give	kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of Business	rindustry		
212	r thau	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Phy	sician			private p	ractice		
þ	othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M				
/lai	Menta Menta rked rice	2	Henry H. Mallette				Bear	trice Mos	ley			
Maryland	2 sho and is ma		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street	t and Number or Ru	ural Route Number,	City or Town, State,	Zip Code)		
<u>2</u>	l and lealth im 27 her ti		Art Mallette/Son	lanh s			Road, Be		le, NJ 079			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 ahow apprintury or other traumatic event, the Mudical Examination in the confiles an once.		20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	cemetery, crer	osition (Name of matory or other pla	1		20c. Location - City or			
Εij	rtmer rtant njury		4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licens						Wilmington			
Ba	Depa Impo any i		21. Signature of Fullerar Service Scens	Varaball	/ 2	z. Name and Addin			Funeral Ho			
· F	Si nin		23a. Part . Enter the disease, or compl shock, or heart failure. List only or	cations that caused the deal	th. Do not ent	er the mode of dy				Approximate		
1	Physician		Immediate Cause (Final	ne cause on each line.	Air	o Am	thomas	7		Interval Between Onset and Death		
100	/Medical		disease or condition resulting in death)	Due to (or as a consec	uence of):	Cu	HIVING	17				
В	Examiner		Conventially list conditions	(1110	linmy	unhall	W				
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	ruence of		1900	1				
	ecute and -trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	uonoo of\:	U	/ 0	/				
760,	that the death certificate be executed ed by the ettending physician and detached for use as the burial-transit	cal E		Due to (or as a consec	(derice of).							
687	ficate phys s the											
×	certifi nding use a	/W	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Date of de	livery		
Box	death e ette d for	Iclai	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c]Ectopic pregnanc] Other (s <i>pecify)</i> _	У		Month	Day Year		
P.O.	by the	hys	9 Unknown	9□ Unknown								
S, F	The law requires that the death certifica ate has been signed by the ettending ph page 2 should be detached for use as th	Completed by Physician/Med	Part II. Other significant conditions con	ntributing to death but not ref	sulting in the u	nderlying cause gr	ven in Partil,	23e. Did tob	acco use contribute to			
ord	bluor	ted	- EMA MUS	u xvijaj	(JUL)	UN (1)	<u>((Ceney</u>	1 □ Ye	s 2.M_No 3.∏.Pi ———	robably 4 □Unknown		
Vital Records,	has b	nple	- Allk	wal Ills	alla	I_CUA	an	24a. Was ar autopsy	y prior to	utopsy findings available completion of cause of		
ᄪ	: The							perform 1 Tes 2	ned? death? X No 1 ☐ Yes	2 □ No		
<u> </u>	sician: Th certificate rector, pag	Be c	25. Was case referred to medical examiner?	lospital: عجر		_ 0		ath Check only one	7.00			
of	Attending Physician: If death. ector: After this certified by the funeral director.	: To	1 ☐ Yes 2X No 27. Manner of Death	28a. Date of Injury	28b. Time of	IL 3LI DOA	4 Nursing F	tome 5 Reside	nce 6 Other (Spe	cify)		
on	nding th. :: Afte	tlor	1X Natural 5 ☐ Pending Investigation	(Month, Day Year)	Injury	f 28c. Inju Wo	rk?]Yes 2∐No		,			
Division of	Atts ector by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	reet, factory, office		28f. Location (Str City or Town	reet and Number or Ri	ural Route Number,		
Ö	rs after ai Dir	Cert	To Holling	building, etc. (Special	·y/			City of Town	, Siale/			
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	cal	(Check only Z Medical Exami	sician: To the best of my knowner: On the basis of examina	owledge, death	h occurred at the ti	ime, date and place	and due to the ca	use(s) and manner as	s stated.		
	the hin 2 the land	Medical	one)	and manner stated.								
\	S IN S		29b. Signature and title of certifier			29c. Licen	////-	7	d. Date signed (Mont), Jay, rear)		
			30. Name and address of person who co	mulated cause of death the	n 22a\ /7:	Print	5017		11/9/0	U.		
1	U		DR NASREEN	/ ANGO	7610	~	ROLL AVE	E. TAKI	and Pas	k Md 20912		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	1	CUCI AV	177	UPIN IMA	10.		
	Registi	ar	NOV 1 5 2006	Bearing It.	A STATE OF THE STA							

			For State Registrar	State of Maryland	Departmen	nt of Health and N te of Death		ien 2 0 0 6	36138	
	Physicia /Medic		1. Decedent's Name (First, Middle, Las	ason			2. Date of Death Month	er 13, 2001	3. Time of Death P 3:35 M	
	Examin	C'	4a. Facility Name (If not institution, give	Sq. + Rehab. C	tr. I	Town, or Location of Death Control of The Control	8. Date of Birth	4c. County of Death Year 9. Birth	aplace (State or Foreign	
	Director		Usual Residence of Decedent 10a. State 10b. County	. 50	own or Location		May 12	,1950 Nor	Th Carolina 10d. Inside City Limits	
	th the Man or 28a-f sh e octified	Director	10e. Street and Number	B	altim	Ore ip Code	10	Og. Citizen of What Co	1 (2 Yes 2 □ No untry?	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show or other traumatic event, in Medical Example in Item of lifed at	by Funeral D	3460 Park F 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Deci	adent of Hispanic Origin? (Siecify Cuban, Mexican, Puerti Mo Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White Specify: D		
Maryland 21215-003	d within 72 hou giene. er than "natura , the Medical E	Completed	15. Decedent's Ed (Specify only highest gra-		6a. Decedent's Usi (Give kind of w life. DO NOT	ork done during most of wor	king	Priva	industry te	
yland	should be file nd Mental Hy marked othe imatic event,	To Be (17. Father's Name (First, Middle, Last) Charles R	Mason		Ine	ne (First, Middle, M	agins		
timore, Mar	Pages 1 and 2 shinent of Health and int: If Item 27 is miry or other traum		19a. Informant's Name/Relationship (7 MCS. The Z MC 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	20b. Plac	19b. Mailing Address 3 4 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	is (Street and Number or Ru A K Height ame of other place)	s Ave.	Eity or Town, State, 2 Bills 20c. Location - City or	1.21215	
Baltii	permit. Page Department Important: If eny injury o		21. Signature of Funeral Service Licen		22. Name a Josep 2272 V	Ind Address of Facility Ch. L. Russ V. North Ave	Funeral	Home, P.A.		
	Physician /Medical Examiner		23a. Part Enter the disease, or composition of the composition of the composition of the composition resulting in death) Sequentially list conditions.	olications that caused the death. In cause on each line. Termina Due to (or as a consequer	e acq		_	eng Synd	Approximate Interval Between Onset and Death	
8760,	icate be executed physicien and the burial-transit	dicai Examiner	and figure and the control of the co							
P.O. Box 68	The law requires that the death certifica ste has been signed by the attending phage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3 Ectopic			23d. Date of deli Month	very Day Year	
Ś	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death but not resulting	ng in the underlying	cause given in Part I.		pacco use contribute to es 2 ☑No 3 ☐ Pr	the cause of death?	
Vital Record		Completed					24a. Was a autops perform	y prior to death? 2 ☑ No 1 ☐ Yes	topsy findings available completion of cause of 2 No	
of Vit	Physiclan: r this certific ral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital:	NOutpatient 3 [Other: 4 Nursing H		ence 6 Other (Spec	cify)	
Division	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Certification:	1 Anatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury M	28c. Injury at Work? 1 Yes 2 No		ow injury occurred	10	
ο	oital or A		4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)			City or Towr			
	he Hospital on 24 hours all he Funerel Dietely filled i	edicai		ysician: To the best of my knowle niner: On the basis of examination and manner stated.						
	To the ly within 2. To the complet	Σ	29b. Signature and title of certifier	Kp m		9c. License number	2	9d. Date signed (Monti	h, Day, Year)	
•	7		30. Name and address of person who milen - Oper Kith	and a series of death (Itan 2)	3a) (Type, Print)	P31865	tan st	Bast	hd 2:5	
	Sta Regist		31. Date filed (Month, Day, Year) NOV 1 5 2001	32. Registrar's Signatur	o done	-1 W	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		-120/	

			For State	State of Marylar		artment of F			ene g. No. 2006	36139	
			Registrar 1. Decedent's Name (First, Middle, Las	st)		Timoate of	Douin	2. Date of Death		3. Time of Death	
	Physicia /Medic		Leander		Mas			Month	1 ² 2 2006	9:35а м	
	Examin	er	4a. Facility Name (If not institution, give Future Care Sa:	· ·		,, ,	Location of Death	h 4c. County of Death			
	Funeral Director		5. Social Security Number 6. S 230-66-8506	ex 7. Age (<i>In yr</i> s	. <i>last birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01-08-1	Year) Co	hplace (State or Foreign untry) Va.	
	D		Usual Residence of Decedent		· •						
	Marylar I-f show fled at	tor	MD 10b. County N	/A	ity, Town or Lo Baltim					10d. Inside City Limits X⊠Yes 2 No	
	with the	Director	10e. Street and Number 2414 E. Biddle	Street		10f. Zip Code 21.2	213	10	g. Citizen of What Co USA	untry?	
9	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	/ Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1□Yes 🏋No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	e, etc.	
-003	'2 hours natural", Ical Exa	ted by	3 ☐ Widowed 4 ★ ★ Divorced 15. Decedent's Ec (Specify only highest gra	Year or Dates:	16a Dece	dent's Usual Occur	ation	ring 1	6b. Kind of Business/	Black Industry	
21215-0036	filed within 72 Hygiene. hther than "natent, the Medica	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		lf employ	during most of work i) 7ed	ang	Home Imp	covement	
and ;	12 should be filed w h and Mental Hygie 7 Is marked other t traumatic event, th	To Be C	17. Father's Name (First, Middle, Last) Warner	Mason			18. Mother's Nam	e (First, Middle, M a F	faiden Surname) Hill		
	nd 2 shou alth and M 27 Is mar r traumat	-	19a. Informant's Name/Relationship (Sophia Mason-da				and Number or Ru deral St.		City or Town, State, 2	Zip Code) 1213	
altimore,	Pages 1 and 2 nent of Health int: If Item 27 I iry or other tra		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	20c. Location - City or Baltimore	Town, State MD						
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	ss of Facility Iorth Ave	March F , Baltiπ	T.H. East more, Md.	21202				
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the dea one cause on each line. a	Imm	ter the mode of dyir	ng, such as cardiac	0/	st,	Approximate Interval Between Onset and Death	
8760,	ate be executed hysloian and the burial-transit	dical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse							
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnanc	y		23d. Date of del Month	ivery Day Year	
ds, P	uires that signed b Id be deta	ρ	Part II. Other significant conditions of	contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.		acco use contribute to s 2 □ No 3 □ Pr		
Division or Vital Records,	sIclan: The law require contilicate has been sidirector, page 2 should b	Completed						24a. Was an autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of 2 No	
ΖĦ	siciar certificacto	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 [□ER/Outpatier	oth		th (Check only one			
0	Attending Physician: r death. ector: After this certific. by the funeral director,	n: To	27. Manper of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe hou	nce 6 Other (Spe w injury occurred	спу)	
į	endin ath. or: Aft he fun	atio	1 ☑ Natural 5 ☐ Pending investigation	1	Injury		Yes 2 □ No				
Divis		Certification:	3 Suicide 6 Could not be determined	e 28e. Place of injury - At building, etc. (Spec	home, farm, str cify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru , State)	ıral Route Number,	
	To the Hospital of within 24 hours aft To the Funeral D completely filled in	Medical (nysiclan: To the best of my kr miner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier	lja		29c. Licens	number 7537	29	Od. Date signed (Mont	h, Day, Year)	
	57		30. Name and address of person who	completed cause of death (Its	em 23a) (Type,	Print) DUNTROYA	l Ave, Bi	ALTIMOR	2E MD 21	217	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Regidar's Sign	nature	houtes					

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H rtificate of L			ene 2006	36140
	Physici	an	Decedent's Name (First, Middle, Last, Jack Malp.					2. Date of Death Month OVEMber	Day 2006	3. Time of Death
3	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	ovember	11, 2006 4c. County of Dea	12:45 PM
	ZXXIIII		Carroll Hospital	Center		Westmin	nster		Carrol	1
	Funeral Director		210-09-948/	7. Age	90 Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day,) April 4,	9. Bi	nthplace (State or Foreign ountry)
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	a-feh	ctor	Maryland Carroll		Sykes	ville				1 □ Yes 2 XNo
	or 28	Directo	10e. Street and Number			10f. Zip Code		100	g. Citizen of What C	ountry?
	e 23e	eral	7200 Third Avenue	12. Was Decedent B	Everia II C 12	21784		du Voe er Ne	USA 14. Race - Am	oriogn Indian
036	be filed within 72 hours after death with the Maryland lat Hyglene. d other then "natural", or Iteme 23e or 28e-f ehow event, Ite Madical Exacidest must be routified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	do	if Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Spec in, Mexican, Puerto R Specify:	ican, etc.)	Black, Wh	te, etc.
2 2	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occupa	ation during most of working	7	6b. Kind of Business	/Industry
Maryland 21215-0036	within iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retired Scopal Pri			Clerg	J.
פ		Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma		
Z		70	Edgar Cyril Malp					a Costir		
Mar	2 2 2	1	19a. Informant's Name/Relationship (T) Hilda C. Malpas,				and Number or Rural			
	s 1 end 3 if Heelth Item 27 other tr		20a. Method of Disposition	Dadgirect		osition (Name of imatory or other place	n Avenue M		LVET MD 2 Dc. Location - City o	
Ë	00		1 ☐ Burial 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		ematory Ir	1	/06 E	Baltimore.	Maryland
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Boens Thomas Gregor	90			Society O cick Road		and,Inc.	and 21228
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each lin	the death. Do not en	ter the mode of dying	g, such as cardiac or	respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	. Mac	I laiban	ntaretin	n			Onset and Death
	/Medical Examiner		resulting in death)	Due to (of as	a consequence of):	05.0 ag	. 0			i 1677
	-	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):	J Mice	\\ \			3-4)
/	ecuted and transi	Examlner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
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_	·= On di	Medical	IF FEMALE:							
O. Box	The law requires that the death certifules has been signed by the ettending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23d. Date of de Month	olivery Day Year				
ds, P	uires that signed by	ρ	Part II. Other significant conditions con	ntributing to death but	-	underlying cause give	en in Part I.	23e. Did toba		o the cause of death?
Vital Records,	: The law require cete has been sig page 2 should b	Completed	Acte on Chro	nic Ren	el Frilan	2		24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
E E		Bec	25. Was case referred to medical examiner?				26. Place of Death	J	ZNo 1□Ye	s 2□ No
	Physician: r this certifice ral director, p	၉	1 ☐ Yes 2 ☑ No	lospital: 1 Inpatie			4 □ Nursing Hom		ce 6 □Other (Spe	ecify)
<u>0</u>	ding P. Afte fune	atlon;	27. Manne of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Y Year) 28b. Time (Injury	Work	/ at <br Yes 2 □ No	3d. Describe how	injury occurred	
Division of	Hospital or Attending Physician: 4 hours after death. Funerel Director: After this certification filled in by the funeral director,	Certification;	3 Suicide 6 Could not be determined				et and Number or Rural Route Number, State)			
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best oner: On the basis of and manner sta	of my knowledge, dea examination and/or in ited.	th occurred at the tim nvestigation, in my op	ne, date and place, ar pinion, death occurred	nd due to the cau d at the time, date	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To T To I	Σ	29b. Signature and title of certifier	ma		29c. License	number	296	d. Date signed (Mon	th, Day, Year)
3	0		30. Name and address of servers in	L' 10	eath (Item 33c) /T	13 S	5187		voucembl	12, 2006
	Sta		30. Name and address of person who co	ushner,	eath (Item 23a) (Type (Type) ar's Signature	(Businers	(entr D	rive R	extespun,	MD 21136
	Registr		NOV 1 5 288	6	k d					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEDN TIEM# / 10c&16b, perFII, e861, 11/15/06 WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** MEALPIN 16:40 M UCINDA November 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital NA Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2**⊠**F 55.49 Yrs. 115 . 52 . 8398 Director 20. 1956 Usual Residence of Decedent 10a State 10b Counts 10d. Inside City Limits r than "naturel", or Iteme 23a or 28a-f show the Medical Examiner must be notified at WINDSOR MILL. HANDAUSTOWN Director 1 ☐ Yes 2 X No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CIRCLE WESTERN WINDS 21244 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ģ Specify: 3 ☐ Widowed 4 🗖 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. PERMANENTE Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL ASSISTANT 12 TH GRADE KAISER PERMANENTA NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MCCRAY SWEAT MYLOUS RICH ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth (DAUGHTER) NICOLE ALPIN WALDEN DAK CT. BAUTO. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Importent: If ite any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State KING PARK 4 ☐ Donation 5 ☐ Other (Specify) 11-16.06 RANDAUSTOWN , MD 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BAUD. NATL PIKE, BAUD. MD 21 21. Signalure of Funeral Service Licensee aushn MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Myelogenous ACUTE vear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execute. Examiner Due to (or as a consequence of). physician and s the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 No this certificate 1□ Yes Division of Vital After this certification 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident the within 24 hours after deal To the Funaral Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ö 1) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 | Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NAVEEN FEMMARATU, Medical Doctor Res-000 9,2006 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore

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31. Date filed (Month, Day, Year) NOV 1 5 2006

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h, Day, Year) 32. Régistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Malcolm 1130 AM November 13,2006 2000 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Johns Hopkins Bayview Medical Center
5. Social Security Number 6. Sex 7 Ana //n ure loss kinds Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 214-40-2090 65 Yrs Director Aug. 16,1941 Kentucky Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Iteme 23a 8027 Delhaven Road 21222 United States death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after details and Mental Hygiene.

The marked other than 175 in marked other than 1 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ≥CXNo Specify: Completed by Specify 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygies Important: If Item 27 is marked other tt any injury or other traumatic event, Ital 2016. Own Home 11 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Lonnie Weaver Monnie Blevins ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kimberley Burket (Niece) 104 Honor Way Madison, Alabama 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 11/15/2006 Oak Lawn Cemetery Baltimore, Maryland **↓**□Donation 5 □Other (Specify) 21. Signa e of Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Colonic perforation disease or condition resulting in death) 5 days /Medical Due to (or as a consequence of): Examiner Large bowel obstruction S. u.min.y ist concilens if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit of carcinoma of the bile duct d years resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐Ectopic pregnancy 2 Fetal death Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown this certificate has been signed by ral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ recent abdominal surgery Completed 1 ☐ Yes 2 NNo 3 Probably 4 Unknown , bronchiolitis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 21 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funeral D 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie (Check only ê Ç 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W. Brismone detero -V Works mo RES-000 November 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Choreview B. Meiter - Memy, 4940 Faren Arenve, Baltimore, MD alday 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NUV 1 5 2008 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November By **Physician** 2008 11:05 pm Eole Bianca Maranto /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist 8. Date of Birth Dec. 21, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Yea 1914 Days Hours Months Itany 216-34-7665 1 □ M 2 🛛 F 91 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Md. Baltimore Towson Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21286 616 St. Francis Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: White Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Josephina Zappacosta Joseph Zappacosta ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 616 St. Francis Rd. Towson, Md. 21286 Cathy M. Fetzek/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify ntombment 11-13-06 Dulanev Valley Mem. Timonium, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIRETMONIA ountion Physician weeks disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Solution and the second state of the second Physician/Medical Examiner sician and Stroke Due to (or as a consequence of): attending physician for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No has le 2 page certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ☐ S 1 ☐ Yes 2 ☐ No 3□ DOA 1 🗌 Inpatient 2 ER/Outpatient ۵ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the death certificate be executed

Box 68760.

P.0.

Division or Vital Records,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year NOV 1 5 2006

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completes cause of death (Item 23a) (Type, Print)

29c. License number

25205

29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death ((tem 23a) (Typh Print)		With To	2	29b. Signature and title of certifier	(1) al	MI	11) 2	oc. Ucens	1365	? ~?	1 ≥9d	Date signed (Mon	V 9, 2006		
30. Name and address or person who completed cause or death (litem 23a) (types Print)		. 0		meny (w \		D-i-n)		, ,) 1	//	// -	0)		
Teorge E. Miches the 100. 301 Mosfie French 2006		12		JU. Name and address of person who co	LCC M		53	101 k	OSpit	al f	Drive,	Ven B:	unie, 20061		
State State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	for the						- 04(

DHMH 17 Rev 1/2001

Neussany, Shirley

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3, 2006 NOVEMBE'R 02:55A **Physician** Clara G. Owings /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Examiner Center Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs. Feb 28, 76 213-30-1488 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No MD Baltimore Towson Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number within 72 hours after death with 500 Virginia Avenue #1104 21286 USA Funeral unk 12. Was Decedent Ever in U.S. Armed Forces?

Iarried 1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: 2 3 Widowed 4 Divorced īink Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Haalth and Mental Hygiene (important: If item 27 ie marked other then any injury or other trainmeth. Elementary/Secondary (0-12) Coflege (1-4or 5+) unk unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21204 St. Joseph Medical Center 7601 Osler Drive Towson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 NOther (Specify) in state ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Foneral Service Licensee Ronald Wade, Lifector Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY EMBOLUS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed the attanding physicien and hed for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. F cate has been signed by the a page 2 should be detached a 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, 2 No 3 Probably 4 Unknown SEVERE MITRAL REGURGITATION 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 2 No 2 No 1 Tyes 10 funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation efter death. 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) l in by t 4 Homicide ŏ within 24 hours of To the Funeral D completely filled is Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated . 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific D24034 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh 7601 OSLER DRIVE TOWSON, MARYLAND 21204 TIMOTHY LOW, M. D 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State THE STATE OF NOV 1 5 2006 Registrar

BRIAN C. POPE UN

-08600	Please Type or Print in Black Indelible Ink			
IK UNK.	State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death	ygiene	200	6 3614
	Registrar 1. Decedent's Name (First, Middle, Last)	Reg 2. Date of Death	No COO	
Physician/ edical Examine)ay Year 1, 2006	3. Time of Death 2132 hrs
7	4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2105 Garrison Blvd. Baltimore		4c. County of Deat	1
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or
Director	2/2-06-9738 1×M 2 F 36 Yrs. Months Days Hours Min.	1 / /	1970 Foreig	on MARYLAND
ż	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
D now 81	MARYIAND BALTIMORE RANDALLSTOWN			1 Yes 2 No
arylan 8a-f sl atom	10e. Street and Number 10f. Zip Code	10g	Citizen of What Cou	ntry?
er death with the Maryland or items 23a or 28a-f show any must be notified at once. Finneral Director	8608 PILSEN ROAD 21133		U.S.A	•
ens 2.	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 1) Navyor Marriad Status 14. Marital Status 15. Was Decedent Ever in U.S. 16. If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,
er dear	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: BL	ACK
nurs afte	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v		6b. Kind of Business/	
5-0036 ed within 72 hours lygiene other than "natu he Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)		SELF EMP	loyed
1 withing giene Brer the Ned	17. Father's Name (First, Middle, Last) RECYCLER 18. Mother's Name	(First, Middle, Ma	iden Surname)	
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traunnatic event, the Medical Examiner must be notified at once To Re Completed by Funeral Director	AUBREV C. POPE 19a. Informant's Name/Relationship (Type, Print,) 19b. Mailing Address (Street and Number or F	~		
hould hould and Mer is man			., ,	,,,
MD 2 sho ealth and 2 seem 27 is raumati	BARBARA SWANN /MOTHER 8608 PISEN ROAD, RAN 20a. Method of Disposition (Name of cemetery,	10A 15+0a	Oc. Location - City or	VD 21133
Ges 1 at of He	crematory or other place)			
Baltimore, bermit Pages I an Department of Hea Important: If iter injury or other tra	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The HG II PARK HG TS.	DERRIC	K C. JOH	JUHICY MANA
Ba Perr Dep Injin	HOII PARK HOTS.	Ave., B.	ALTIMORE,	md. 21215
Physician /Medical	23a Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound of Head Due to (or as a consequence of):			Death
	Sequentially list conditions, bb.			
ario e	if any, leading to immediate cause. Enter Underlying Cause (Chicago Cause) C. Due to (or as a consequence of): c. C.			
ed nsit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
oe executed cian and rial - transit	UNPENDED		-	
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cox 68760, each certificate be estending physicis for use as the burit estician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	sncy	Month	Day Year
00 P Z P 2	1 Yes 2 No 9 Unknown 9 Unknown	1		
ords, P.O. Bo w requires that the deal is been signed by the at should be detached for plated by Phys			acco use contribute to 2 ✓ No 3 Pro	
- 8 on o		24a. Was an		itopsy findings available
Records, The law requires ficate has been sig.; page 2 should be		autopsy perform	prior to death?	completion of cause of
tal Rection: The certificate ector, page	25. Was case referred to medical 26. Place of Death (Check	only one)	No 1 ✓ Y	es 2 No
of Vital Records, ng Physician: The law require there this certificate has been si meral director, page 2 should the	examiner?		esidence 6 🗸 Othe	r: Scene
n of Ving Ph	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 2 Sc. Injury at Work?	28d. Describe how Subject shot	w injury occurred	
Sior Attend death death sctor: by the	2 Accident Investigation Nov 11, 2006 2125 hrs		not and Number of D	and Dougla Norther Ortic
Division of Vital lospital or Attending Physician: I hours after death uneral Director: After this certify filled in by the funeral director. Corrification: To Bo	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Townhouse / Rowhouse	or Town, Stat		iral Route Number, City d.
Di To the Hospital within 24 hours a To the Funeral I completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and			
To the Hos within 24 h To the Fun completely	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred a find manner stated			
2	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d Date signed <i>(Mo</i> November 12, 2	
	30. Name and address of person who completed cause of death (Item 23a)			
	Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
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DHMH 17 Rev 1/200	ORIGINAL	······································		
OCME 2006				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Doris Elizabeth Peregoy Nov. 1:46 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center for Hospice Care Towson If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth May 15, 1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MaryTand 217-24-6540 Director Usual Residence of Decedent 10c. City, Town or Location 10h. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 916 Lindellen Ave. 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lunch Lady Public School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Simmonds, Sr. Ella Mae Ford 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any Injury or other trau once, 5511 Weywood Dr., Reisterstown, Md. 21136 Jean M. Przylepa - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Reisterstown U.M. Ch. Cem. Nov. 17,2006 Reisterstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or s a consequence of): **Physician** Cumites /Medical Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 May 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 10 Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) () 10 () 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 Is marked other than

r 28a-f show notified at

an "natural", or items 23a or Medical Examiner must be r

the

The law requires that the death certificate be executed and burial-trai physician the as nse for the by signed to peen certificate has the irector, page 2 s funeral director, this After t Hospital or Attending thin 24 hours after continued the Funeral Director: Af

2

31 Date filed (Month, Day, Year) State Registrar

Medical

(Check only one) 29b. Signature and title of certifier

4 Homicide

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29c. License number D 58303 29d. Date signed (Month, Day, Year) Vovember 14 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print harres

BATTURE M

Physician Medical Examiner

ed by the attending physician and detached for use as the burial-tran

been signed by t should be detach

has certificate

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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

filled in by the funeral

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed:
Department of Health and Mental Hygii
Important: If Item 27 is marked other
any injury or other traumatic event, <u>it</u>

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

Director

Funeral

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Completed

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Physician/Medical

Completed

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Certification:

Medical

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any course ground that initiated events resulting in death) Last

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

OLD CEREBRAL INFARCTION

	- 47
24a. Was autoj	psv
perfo	rmed?
1☐ Yes	2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No

25. Was case referred to medical examiner? 1 🗌 Yes 2**∕⊆** No

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred

26. Place of Death (Check only one)

27. Manner of Death 1. Natural 5 Pending investigation Accident 6 ☐ Could not be

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 ☐ Homicide

📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

determined

29c. License number D28281 29d. Date signed (Month, Day, Year) NOVEMBER 13, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9131 Piscataway Road, Suite 600, Clinton, MD Dr. Benjers, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registra

5 2006 NUA

			For State Registrer	State of Mary			of Health a	and Me		ene g. No.2 ()	106	36149
			1. Decedent's Name (First, Middle, Last)						2. Date of Death	Day	Vans	3. Time of Death
	Physicia		Anthony Dani	el Pagliar	coli				Nov 14,	Day 2006	Year	5:30 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give			4b. City, To	wn, or Location o	f Death			ity of Death	
	Examin	ŭ	St. Thomas Moore	Nursing & F	Rehab	Hyati	tsville			Prin	ce Geo	orge's
	Funeral		5. Social Security Number 6. Sec	7. Age (II	n yrs. last birthday)	If Under 1 \	Year If Under 2	24 Hrs.	8. Date of Birth (Month, Day,		9. Birthp	place (State or Foreign
п	Director		579 62 1526 XX	^{1M 2□ F} 58	Yrs.	Months	74,5		Jan 29,	1948		nington DC
	p ,		Usuel Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation						10d. Inside City Limits
	aryla shov	ير			•							1 Tyes 2 No
	8e-f	ctc	N/A N/	A	Washing	1			1.0	0		ΛΛ
	dith th	Ē	10e. Street and Number	_		10f. Zip Co			10	g. Citizen o	f What Cou	nury r
	s 23e	by Funeral Director	3117 P. Street S.		- in II C 12		20020	nin2 /Cnnn			d Stat	
	ter deal	nu	TI, Maria States	12. Was Decedent Eve Armed Forces?		If Yes, specify	nt of Hispanic Orig Cuban, Mexican	, Puerto R	ican, etc.)		lack, White,	
36	rs aft	Ϋ́	Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	NayYes 2 □ Nov NYes, Give Year or Dates:	ietnam	1 ☐ Yes 20	No Specify:			Spec	ity:	White
21215-0036	72 hours after death with the Maryland natural; or thems 23e or 28e-f show Jical Evaluate or notified at	ed	15. Decedent's Edu		16a. Dece	dent's Usual C	Occupation		1	6b. Kind of	Business/In	
15	in 72	piet	(Specify only highest grad	e completed)	(Give	kind of work of DO NOT use i	done during most retired)		g			
212	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Ai	r Craft	t Mechan	ic		Air F	orce	
g	illed Hygie other	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle, M.	aiden Sumi	ame)	
<u>a</u> n	ould be Mental Marked o	To B	Daniel Pag	liaroli			Ma	rv Me	rciai			
Maryland	d 2 should be filed within 72 hours after death with the Marylan it and Mental Hygiene. 77 is marked other than "naturat", or flems 23e or 28e-f show treumatic event, the Medical Examination in the notified at	-	19a. Informant's Name/Relationship (T)	pe, Print)	19b. Maili	ng Address (S	Street and Numbe	r or Rural	Route Number,	City or Tow	n, State, Zip	Code)
	1 and 2 Health a lem 27 is		Elda Sume (Siste	r)	1640	7 Point	ter Ridge	e Dri	ve. Pow	ie. M	D 2071	16
Baltimore,	is 1 and of Healt item 2 other		20a. Method of Disposition		20b. Place of Dispo cemetery, cre-	osition (Name matory or othe	of er place)NOV	20. ^{Da}	006	Oc. Location	n - City or To	own, State
Ę	Page ent o nt: # ry or		*A Burial 2 □ Cremation 3 □ F *4 □ Donation 5 □ Other (Specify)	lemoval from State			n Cemete			Silve	r Spri	ing MD
Ħ	permit. Pages Department of h Importent: If ite any injury or of		21. Signatur Fun Servi e Licen	96	.) 2	2. Name and A	Address of Facility	y Lee	Funeral	Home	. Inc. 6	6633 01d
ä	Departiment of the sany in san		SA THE	MO146			dria Fer					20735
			23a Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the	death. Do not en	ter the mode o	of dying, such as	cardiac or	respiratory arres	st,		Approximate Interval Between
9	Physician	ļ	Immediate Cause (Final	Sind Itaa	Mult	nlo.	Sclen	1 21	•			Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a c		pre	-01	0 214				- College
	Examiner											
		Jer	Sequentially list conditions,	Due to (or as a co	onsequence of):							
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
oʻ	exectan an an rial-tu		resulting in death) Last	Due to (or as a co	onsequence of):							
,160		cai		d								· · · · · · · · · · · · · · · · · · ·
89	leath certificat attending phy I for use as th											
Вох	death certifica e attending ph od for use as th	2	230. was decedent pregnant	3c. If yes, outcome of p		⊒Ectopic preg	nancy				Date of delive	
	0 0 0	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at tim		Other (speci				,	Month	Day Year
P.0	t the d by the tached	Physician/Med	9 Unknown	9LI UNKNOWN				-	-	1		
	The law requires that the death ate has been signed by the atte page 2 should be detached for	γ	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	inderlying cau:	se given in Part I.		23e. Did toba	acco use co	intribute to t	he cause of death?
ğ	w require been sig should b	ed	Stage & Jain	e carrie	Carte				1 🗆 Yes	2 □ ¶o	3 🗀 Prob	oably 4 □Unknown
ပ္ပ	law requ ss been 2 should	piet	Dy varience	•					24a. Was an autopsy		. Were auto	opsy findings available impletion of cause of
æ	The lay te has	Completed by	Encoheles	alm -					perform	ed?	death? 1 ☐ Yes	2□ No
of Vital Records,	ician: Th certificate ector, pag	0	25. Was case referred to medical				26. Place	of Death	(Check only one			
<u>></u>	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No	lospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA	Other: 4 Nu	rsing Hom	e 5 🗆 Resider	nce 6 □C	ther (Specif	(y)
	g Ph Ter th		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time o	of 28c	Injury at Work?	2	8d. Describe hov	v injury occ	urred	
Ö	ath. r: After e funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,	М	1 ☐ Yes 2 ☐ I	No				
Division	or Attenoration after death Director:	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, st	reet, factory, o	office	2	Bf. Location (Stre		nber or Rura	al Route Number,
Ö	ospitel or Attendi hours after death. Inerel Director: A ly filled in by the fu	Certification:		555ig, 6.6 (-,,/							
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page			sician: To the best of n								
_	n 24 he Fu	Medical	one)	and manner stated		ivesugation, in	my opinion, deal	ar occurre				
	To the within To the comple	Σ	29b. Signature and title of certifier	17	, 0	29c. L	icense number	~ ~			ned (Month,	
			Janlan	Levore	Com	1	DOUS	1	1	4100	ven	491 4026
1	16		30. Name and address of person who o	ompleted cause of deat	h (Item 23a) (Type		Λ	111		- /	11.0	- a.D.
9	17		PAUL A WEVER	8 M4 42	3 CLUE	ewb	one Ra	H	1915	v. 42	ulp	4912026 Ze781
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	and s	v					

completely filled in by the funeral Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ignitica M. Sillianisto H0058032 11-14-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Williams, D.O. 6001 Muncaster Mill Rd. Rockville, MD 20855 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006 **ORIGINAL**

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760, within 2

TES ZI NO	. 1 ☐ Inpatient 2 ☐ EH/Outpatie	ent 3 DOA 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. Mann f Death 1 Autural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how injury occurred	
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route City or Town, State)	Number,
			ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the ca	use(s)
29b. Signature and little of certifier		29c. License number	29d. Date signed (Month, Day, Ye	ear)
MM	i con	200835	8 404 15 2	.006
30. Name and address of person who co	ompleted cause of death (Item 23a) (Type	e, Print) 8903 HA	REDED RODD 21	1234
31. Date filed (Month, Day, Year)	32. Registrar's Signature			
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Stat Registra

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			For State	state of Maryla	ind / Department of I		Hygiene	5 36152
			Registrar		Certificate of		Reg. No U U	00101
	Dhysisi		Decedent's Name (First, Middle, Last)			2. Date (3. Time of Death
	Physici /Medio		Happy Richard			Nov		006 0655 AM
	Examin		4a. Facility Name (If not institution, give str	eet and number)	4b. City, Town,	or Location of Death	4c. County of D	
			Shady Grove Adi	ventist He	spital Rock	iville	Monta	oneru
	Funeral		5. Social Security NumbelLINK 6. Sex		s. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Mont. (Mont.	of Birth	Birthplace (State or Foreign Country) unk
	Director		1 1 1	M 200 F	41 Yrs.	Dec 1	h, Day, Year) 12, 1964	uiik
_	pu ,		Usual Residence of Decedent 10a. State1111k 10b. County	unk 10c. 0	City, Town or Location		unk	10d. Inside City Limits
	anylan •how	_	10a. Stateunk 10b. County	ulik 10c. 0	City, Town or Location		ann	unki 🗆 Yes 2 🗀 No
	the Mary	cto			····			
	ih with the Maryla 23a or 28a-f ehov	Dire	10e. Street and Number		unk 10f. Zip Code	ur	1K 10g. Citizen of What	Country?
	23e	īa						
	eb a	Jue		2. Was Decedent Ever in Armed Forces?	U.S. 13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Specify Yes can, Mexican, Puerto Rican, etc	or No- 14. Race - A S.) Black, W	merican Indian, /hite, etc.
36	or I	γFi	1 Never Married 2 Married	1 ☐ Yes 2 ∰No If Yes, Give	1 ☐ Yes 21 No	Specify:	Specify:	black
08	ura!	D D	3 Widowed 4 Divorced	Year or Dates:	16a Dass dastis Havel Ossu	pation ur	1k 16b. Kind of Busine	ess/Industry unk
7 7	"nai	ete	15. Decedent's Educa (Specify only highest grade of	completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	IK 166. Kind of Busine	ass/moustry Cilic
Richard Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. the rhen "natural", or Itema 23a or 28a-f ehow ent, it a Mydical Exam or must be nytified.	Completed by Funeral Director	Elementary/Secondary (0-12) unk unk	College (1-4or 5+) ₹			4	
73 P	be filed htal Hygid ed other	ပိ	17. Father's Name (First, Middle, Last)		unk	18. Mother's Name (First, M	iddle, Maiden Sumame)	unk
an	ed is b	Be c						
	should ind Men marke	은	19a. Informant's Name/Relationship (Type	Print)	19b. Mailing Address (Stree	t and Number or Rural Route N	lumber City or Town Stat	e. Zin Code)
Z	s 1 and 2 should f Health and Mer fem 27 is marks other traumatic		Shady Grove Hospit			Center Drive F		
Q 0	1 and 2 Health tem 27		20a, Method of Disposition	20b	. Place of Disposition (Name of	Date	20c. Location - City	or Town, State
م و	00		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer	moval from State	cemetery, crematory or other pla	ace)		
HAPP Baltimore,	permit. Pag Department Important: I eny injury o	13	4 Donation 5 Other (Specify)		22 Name and Addr	ess of Facility		
Ba	permit. Pagi Department Important: I eny injury o		21. Signature of Lineral Service Licensee	ide, Difecto	State Ana Baltimore	ess of Facility atomy Board 655 e, MD 21201	W. Baltimon	re Street
	_		23a, Part1, Enter the disease, or complica	ations that caused the de	eath. Do not enter the mode of dy		ory arrest.	Approximate
			shock, or heart failure. List only one Immediate Cause (Final	cause on each line.) 0/	3 ,	,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	HIV/1-	105			unknown
	Examiner			Due to (or as/a cons	equence of):			
		7	Sequentially list conditions, b.	Due to (or as a cons	equanea of).			
	ted nsit	Examiner	lany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	,	,			
	te be executed ysicien and e burial-transit	Xar	that initiated events resulting in death) Last	Due to (or as a cons	equence of):			
760,	e be e) sicien e buria	calE						4
587		gio	0.					10
Box 68	certii Iding	Š	tF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of preg			23d. Date of	delivery
	atter for L	ciar	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time of		су	Month	Day Year
o.	the d y the ched	ıysi	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9□ Unknown				
Division of Vital Records, P.O.	that led b	Completed by Physician/Medi	Part II. Other significant conditions contr	ributing to death but not r	esulting in the underlying cause g	iven in Part I. 23e.	Did tobacco use contribut	e to the cause of death?
sp	urres sign	Ö	Progressive Mu	Itifocal	Leukenceph	alopathy	1 ☐ Yes 2 ☐ No 3 ☐	Probably 4 Unknown
<u> </u>	* req bee	ete	Severa Proto	in calo	rie Malnut	rition 24a.	Was an 24b. Were	autopsy findings available
æ	he la e hes ge 2	Ĕ	300000 110121	71 -000	THE MAINTE	111011	performed? deat	
<u>a</u>	n: T fficate or, pa		25. Was case referred to medical			26. Place of Death (Check		Yes 2□ No
⋚	Physicien: this certifica	o Be	examiner?	spital: 1X Inpatient 2	☐ ER/Outpatient 3☐ DOA	thor	Residence 6 Other (5	Spanify)
ō	Phy or this	1. To	27. Manner of Death	28a. Date of Injury (Month, Day Year)			cribe how injury occurred	эрөспу)
ő	ding th: Afte	100	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		ork? ⊒Yes 2 ∐No		
<u></u>	dea dea ctor y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At	t home, farm, street, factory, office	28f. Local	tion (Street and Number o	r Rural Route Number,
<u> </u>	after Olive	Certification:	4 Homicide	building, etc. (Spe	ocify)	City	or Town, State)	
	spita nours nerei		29a. Certifier Certifying Physic	cian: To the best of my k	nowledge, death occurred at the	time, date and place, and due to	the cause(s) and manne	r as stated.
	To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	edicai	(Check only 2 Medical Examine one)	er: On the basis of exami and manner stated.	ination and/or investigation, in my	opinion, death occurred at the	time, date and place, and	due to the cause(s)
	To th withir Fo th comp	Me	29b. Signature and title of certifier		//	se number	29d. Date signed (M	
			1 LI ON		D58	8681 r Drive, Roc	Novomb	De - 2.2006
			30. Name of add ss of person who com	npleted cause of death (I	tem 23a) (Type, Print)	•	1 4	
		1	Jude Alexander	- 9901 1	dedical Center	r Drive Roc	Kuille, Md.	20850
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature			
	Regist		NOV 1 5 2006	Sign of the same of	3 Stopped			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Ror State Amend item#26, perVerbal, g861,11/15/@er#Hicate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Nov 12, 2006 5:35 A M **Physician** Edeline Rhodes, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Oxon Hill 6805 Livingston Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 10, 9. Birthplace (State or Foreign 6, Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Hours Months 1XX 2□ F May ĬŸ19 Maryland 578 07 6167 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene.
em 27 is marked other than "natural", or Items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Oxon Hill Director Maryland Prince George 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20745 6805 Livingston Road Funeral Race - American Indian, Black, White, etc. 12, Was Decedent Ever in U.S. Armed Forces? 1-F1/Yes 2 □ No WWII IYYes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2√TVNo Specify Specify: White 2 Year or Dates: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Engleman Carl E. Rhodes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2::
Department of Health at Important; If Item 27 is any Injury or other traugnce. 6805 Livingston Road, Oxon Hill, MD 20745 Edeline B. Rhodes Jr. (Son) Nov 17 Pat 2006 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 □Cremation 3 □Removal from State Suitland, Maryland Washington National Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lee Funeral Rome, Inc 6633 011 21. Si n tur of uner I S rice Licens 20735 Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) month Physician METASTATIC Haeno carpinoma /Medical Due to (or as a consequence of) Examiner Month Malignent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence o Examiner be executed burial-tran Due to (or as a consequence of): aftending physician for use as the buria Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9☐Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Disease 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Hyperlipid emic 1 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ EP/Outpo ent- 3□ DOA 1 Yes 2 No Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

award Taller in 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward T. Cullen, M.D. 6188 Oxon Hill Road #704, Oxon Hill, MD 31. Date filed (Month, Day, Year)

5

NOV 1

2006



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D0026607

29d. Date signed (Month, Day, Year)

November 13 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician November 9, 2006 1:50 Alver Р Louis Renew. Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 Coors Dr. Northeast Cecil If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1**X** M 2□ F 216-44-2131 61 Director 5. 1945 Marvland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10b. County 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 ☑ No Md. Baltimore Glen Arm 10e Street and Number 10g. Citizen of What Country? 4427 Langtry Drive 21057 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1XYes 2□No
If Yes, Give
Year or Dates:Vietnam 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Completed by Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis A. Renew, Sr. ပ Dorothy McClendon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Foster/Ex-wife Glen Arm, Maryland 21057

Date 20c. Location - City or Tow 4427 Langtry Dr. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Hilltop Service Corp. 11/14/06 Towson, Maryland Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service License plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or con shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ventricular f. brilletion disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner spital or Attending Physician: The law requires that the death certificate be executed tours after death.

The law requires the death.

The law specificate has been signed by the attending physician and illed in by the funental director, page 2 should be detached for use as the burlan-transit. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 28662 11/10/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO 21236 BRIAN MO Q0 2602

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 5 2008

32. Regiarar's Signature

		•	1 - State Registrar	Otate of Ivia	•			of Deal		, ,	eg. No.		
	Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month		Year	3. Time of Death
16	/Medic	al	Jean D. Rair			44	h City Te	wn, or Location	on of Dooth	NOVEMBE	R 13 20		9:05 P M
4	Examin	er	4a. Fecility Name (If not institution, give s GREATER BALTIM		AT CENTI			WSON	on or Death		BALTI		
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birth	iday) If	f Under 1		der 24 Hrs.	8. Date of Birth (Month, Day			place (State or Foreign
	Director		217-18-1047	M 2 XF	84 Y	rs.	ionins	Jays Hour	is wiii.	Aug. 21	, 1922	Ma	ryland
	and		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Location	ion					1	0d. Inside City Limits
	Mary F-f eh	tor	Md. Baltimor	`e	Towson	n							1 ☐ Yes 2 € No
	with the	Director	10e. Street and Number 615 Chestnut Ave.	#232	-	1	10f. Zip C	21204		1	0g. Citizen of W	hat Cour US	*
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heath and Mental Hygiene. If marked other than "natural", or fleme 23a or 28a-f ehow other traumatic event, the Medical Examinations and the notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			s Deceder es, specifi			ecify Yes or No- Rican, etc.)		, White,	
2-0	72 ho natur	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. l	Decedent (Give kind	t's Usual	Occupation done during n	nost of work	ing	16b. Kind of Bus	iness/In	dustry
121	within ene. then	Completed	Efementary/Secondary (0-12)	Coffege (1-4or 5+)			done during n retired)			O	llama	
9	filed v Hygie other 1		17. Father's Name (First, Middle, Last)	+2		HOME	emake		other's Nam	e (First, Middle,	Own Maiden Sumame		
lan	ould be Mental arked c	To Be	John D.C. Duncar	1					Margu	erite C	Cox		
Maryland 21215-0036	1 and 2 should I Health and Meniem 27 ie marke		19a. Informant's Name/Relationship (Ty) Mr. John E. Raine,	*.						ve. Tows			
Baltimore,	of He of He of He of He of He of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State	20b. Place of I	Disposition, cremato	on (Name ory or oth	of er place)		Date	20c. Location - (City or To	wn, State
ţi	Pages tment of I tant: If it		4 □ Donation 5 □ Other (Specify)		Hillto	14		ce Co.		5-06 _	Towso	n, M	d.
Bai	permit. Pages. Department of Il Important: If Its any injury or of once.		21. Signature of Funeral Service License	68-		22. Na R1	ame and	Address of Fa OWSON ONK RO	Funer 1. Tow	al Home, son, Md:	Inc 21204		
			23a. Part1. Enter the disease, or compfi shock, or heart failure. List only on	cations that caused to e cause on each line	he death. Do no	ot enter th	he mode	of dying, such	as cardiac	or respiratory arr	est,		Approximate Intervaf Between Onset and Death
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	outed nd on	Examine	that initiated events										
90,	ficate be executed physician and stransitions the burial-transit		resulting in death) Last	Due to (or as a	consequence of	f):						1	
68760,	physical physics	Medical	d									-	
P.O. Box (Physician: The law requires that the death certificate be executed this certificate hes been signed by the ettending physician and airector, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 bl No 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal death		topic preg ther (spec				23d. Date Mon		ory Day Year
	s that ned by e deta	by Ph	Part II. Other significant conditions con	tributing to death but	not resulting in	the under	rlying cau	se given in Pa	art I.	23e. Did to	bacco use contri	bute to th	ne cause of death?
ords	w requires been sign should be	ed b	Ascites							1 🗆 Yo	es 2 No	3 🗌 Prob	abfy 4 Striknown
of Vital Records,	law re les be	Completed								24a. Was a	o ve	ior to cor	psy findings available impletion of cause of
al B	: The licate he									perform 1 ☐ Yes		eath?	213 No
Zit.	sician: certific irector,	9 Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:			-0.00	104		h Check only on			
ō	Physe Properties	n: 70	27. Manner of Death	28a. Date of Injury (Month, Day		me of	3 DOA	finiury at Work?	Nursing Ho	ome 5 Reside	ence 6 Othe ow infury occurre		γ)
ion	Attending Ir death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear) in	jury	м	Work? 1 ☐ Yes 2	2 □No				
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	Hospil 4 hour Funera ely filla	Medicai (29a. Certifier 1 Certifying Phys (chack only one) 2 Medical Examin	sician: To the best of ner: On the basis of a and manner state	examination and	death oc	curred at tigation, in	the time, date my opinion,	and place, death occur	and due to the c red at the time, d	ause(s) and man late and place, a	ner as si	tated. the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	2			Ì	icense numb			9d. Date signed		*
			Joson Blac	S MD			D	006	1199		NOV. I	4.7	2006
	10		30. Name and address of person who co	smpleted cause of de	ath (Item 23a) (7	Type, Prin	nt)	(7.	100	7	1000 2	12 -	6,1
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar		100	31	Juite	207,	lowson	1901	120	7
	Regist		NOV 1 = 201	2.2	Ro	A	11 1						

DHMH 17 Rev 1/2001

			For State Registrar		State	of Marylar	-	artmen				lental H	ygien Reg. N	21	06	36157
			Decedent's Name	e (First, Middle	, Last)		_					2. Date of D Month		ay	Year	3. Time of Death
-	Physici /Medio		Leola	Marie	Snyo	der						Novemb			2006	8:55 pm ^M
	Examir		4a. Facility Name (I	f not institution	, give street and n	umber)		4b. City,	Town, o	r Location o	of Death		4	c. Coun	ty of Death	
			Joseph R	ichey H	ospice				imon							
	Funeral		5. Social Security N	lumber	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.		Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth Day, Year	-)	Coun	
	Director		212-30-1		1 M 2 ZZ	73	Yrs.					2/14/1	1933		Mar	yland
	A		Usual Residence of 10a. State	10b. County		10c. C	ity, Town or L	ocalion							1	0d. fnside City Limits
	Aaryli Sho	ō				Dol	1 4 3 3 3 3 3 3	_								1 ☐ Yes 2X No
	the N	ect	Maryland 10e. Street and Nur			Ba.	ltimore	10f. Zip	Code				10g. C	itizen of	What Coun	try?
	With 3a or	<u> </u>	942 Quant	tril Wa	17			212	205				гт	. s.	7\	
	death	Funeral Director	11. Marital Status	CIII Wa	12. Was De	cedent Ever in U	J.S. 13.			lispanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)		14. Ra	ce - Americ	
G	after and a second	Ē	1 Never Marri	ied 2□ Marri	ied 1 Tyes	2 X No						Hican, etc.)			ack, White,	elc.
9	rai", c	b	3X Widowed	4 Divorced	If Yes, G Year or	Dates:		1 🗆 Yes	∠_ 7 440	Specify:				Spec	Wh:	ite
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2	filed within 72 hours after death with the Maryland Hygiene. Hygiene then "natural", or items 23s or 28s-f show ent, the Madical Examiner must be neillised at		9 17. Father's Name	/First Middle	(net)		Barte	ender		19 Mothe	arte Name	(First, Middl		Bar Suma	(me)	
no	be fi	Be							!							
<u>\o</u>	should nd Men marke	ဥ	Carl Rai	ndolph	Brooks		10b Mail	ing Addross	Stroot			Albert		Darr	_	Codel
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparmit. Pages 1 and 2 should be filed within 72 hours after death and Mental Hygiene. Department of Health and Mental Hygiene in Institutal; or Items 23a or 28a-f show eny injury or other traumatic event, the Madical Examination at the multipled at appear.					(D - +1-										
	es 1 and 2 of Health I item 27 i		Robert V		Brooks	20b.	Place of Disp	osition (Na	me of	Į.		Essex			- City or To	
و	Pages nent of int: If its iry or o		1 ☐ Burial 2	Cremation	3 □Removal from	n State	cemetery, cre	-		ce)		14				
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	_		23a, Part 1, Enter 1	the disease, or	complications that	caused the dea								2X,	Maryia	Approximate Interval Between
			shock, or hea	art failure. List	only one cause on	each fine.	(1)	2011	200	che	211				1	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	on	a	o (or as a conse	/ / / / / /		110	44						12/10
	Examiner					7 (01 43 4 601130	4401.00 01,1									
0		jer	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events	ndilions, nmediate	b. Due to	o (or as a conse	quence of):									
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	e des	sici	1 ☐ Yes 2 ☐ 9 ☐ Unknown	X) No	4⊟Preg 9⊟Unk	gnant at time of a nown	death 5	Other (sp	pecify)							
00/ P.O	hat th d by detacl		Part II. Other signif		ons contribution to	death but not re-	sulting in the	ınderiyina	ausa aiv	ren in Part I		23e Did	tobacco	use cor	ntribute to th	e cause of death?
10/18	signe d be c	þ		211	A CONTINUE TING TO	dodin od not ro	Sulling in the t	andonying c	auso giv	OIT III T GILL	•		Yes 2			ably 4 □Unknown
χ U/h		Completed	17,3	1 hard	A.							-				
ec _	The law ste has t	dr.	-///0	FUL	>							24a. Wa	s an opsy formed?,	246	prior to cor death?	psy findings available npletion of cause of
de y sala	r. Th			1								1 ☐ Yes	2) N	0	1□ /es	2 □ No
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₹	Phys rthis ral di	-: To	1 Yes 22	No th	1		ER/Outpatie		77	4 🗆 140		me 5 Res				TUZYIX
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ec/a Division	Attendi death. ctor: A y the fu	flca	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could	ot be 28e. Place	e of Injury - At h	nome, farm, st	treet, factor							ber or Rura	I Route Number,
eo/	after Dire	Certification:	4 Homicide	detain	build	ding, etc. (Speci	ity)					City or To	own, Stai	te)		
~	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier	1 Certifyin	g Physician: To th	ne best of my kn	owledge, dea	th occurred	at the tir	ne, date an	nd place,	and due to the	e cause(:	s) and n	nanner as st	ated.
	the Ho hin 24 t the Fu npletely	Medical	(Check only one)	2 Medical	Examiner: On the and ma	basis of examin nner stated.	ation and/or in	nvestigation	i, in my o	pinion, dea	th occurr	ed at the time	date an	nd place	, and due to	the cause(s)
	To the within To the Comp	ž	29b. Signature and	I title of certifier	1111	016	7	29	c. Licens	e number	٠		29d. D	ate sign	ed (Month,	Day, Year)
			1/4/1	1/1/	MIMA	1/14/1/			1/2	3/1/	7			///	1/A	6
	si s		30. Name and addr	ress of person	who completed car	use of death (Ite	т 23а) (Туре	. Pript) /	1	9	10	10	1/1	0	IL T	11/2/21
	•		JOHA	1 11/19	BUMC	1111	421	1/11	ach	YII		1/1/1		27/	11/1/	M 2/2/
		ate	31. Date fifed (Mon	nth, Day, Year)	2004 32.	Registrar's Sign	nature	, el			- 00	117			1	/
	Regist	rar			W 2000	The Alekan	13.	dinger!	200							

State of Maryland / Department of Health and Mental Hygiene 0 6 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Vosember 10:50 A M Baby Boy Shields 2006 /Medical 4b Qity, Town, or Location of Death 4c. County of Death Eacility Name (If not institution, give street and number) Examiner le If Under 24 Hrs. 8 Date of Birth Min. Min. Month, Day, Year) Jennes Hopleines TIMORE Dita 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 4 1**X**M 2□ F Yrs. Nov 4, Maryland Director none Usual Residence of Decedent with the Maryland 10d. Inside City Limits r 28a-f show 10a. State 10b. County 10c. City, Town or Location ty Yes 2 □ No MD Baltimore 10e. Streel and Number 10f. Zip Code 10g. Cilizen of What Country? Examiner must be ā 1728 Harford Avenue 21213 USA Pages 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black þ 3 ☐ Widowed 4 ☐ Divorced "naturef" al Hygiene. I other then "nature event, the Medical E 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ie marked Acie Hines Paula Shields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johns Hopkins Hospital item 27 i 600 Wolfe Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of importent: if any injury or once. 4 □Donation 5 ☑Other (Specify) in state 21. Signature of Euneral Ser Rona State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Enler the disease, or complications that shock, or heart failure. List only one cause on used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between set and Death Immediate Cause (Final Premoturit Extreme **Physician** hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No certificate has I irector, page 2 s Yes 2 No 25. Was case referred to medical Be 26. Place of Death | Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 □ ER/Outpatient 3 □ DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending To the recent after death.

You the Funarai Director: After the Funarai Director. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29b. Signature and title of certified 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) , CMSC 2, JHH GOON Wolfe ST. Baltimore MI NICU · Northington, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 07^{Day} **Physician** Month Laura Sivells 200්දී М 6:a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6104 Walther Ave. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–28–1929 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Months Days Hours Min. 217-32-7666 Md. Director 76 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director Md. NA Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 6104 Walther Avenue 21206 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: "natural", or items dical Examiner ma 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Black Specify: 3 XWidowed 4 ☐ Divorced artment of Health and Mental Hygiene.
ortant: If Item 27 is marked other than "natui
injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Asst. St. Agnes Hosp. 12th grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Robert Macklin Mattie Stokes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Knox 6104 Walther Avenue, Baltimore, Md. Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriar 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) 11-13-06 Baltimore Nat. Cem. Baltimore, Md. 21. Si nature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East MA 1101 E. North Ave., Baltimore, Md. 23a. Fart1. Enter the disease, or complications that caused the death. shoc , or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician di ease or condition resulting in death) /Medical Examiner ereprovascular accidents Sec entially list conditions, if ny, leading to immediate cause Entire III. The Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, cate has been signed by the attending physician , page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Yo Month Dav Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ heles melli 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 201 No 24a. Was an certificate 200 No emia 2 No 1∐ Yes 25. Was case erred to me cal examiner. Physician: funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Tes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 5 Mesidence 6 ☐ Other (Specify) 28a. Date of Injury Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending (Month, Day Year) 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and little of certifier

31. Date filed (Month, Day,

de and address of persen who completed cause of death (Item 23a) (Type, Print)

001

Year)

6701 NU

32. Registrar's Signature

29c, License number

Charles St Ste 5201

29d. Date signed (Month, Day, Year)

			For State Registrar	State of	Maryland		artment <i>tificate</i>					giene	006	36160
	Physici	an	Decedent's Name (First, Middle, Jovan Jole Sto								2. Date of Dea	Day	1 200	3. Time of Death 1.30 P M
	/Medic Examin		4a. Facility Name (If not institution,	give street and num			4b. City, T				Novem	4c. 0	County of Dea	th
			Frederick Villa			and himbolass	Ca		ville		8. Date of Birth		Baltimo	thplace (State or Foreign
	Funeral Director		5. Social Security Number 106–24–7039	1⊠M 2□F	7. Age (In yrs. Ia 89	Yrs.		Days	Hours	Min.	July 6,	v. Year)	C	oslavia
	w w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Maryl s-f sho	tor	Maryland Bal	timore	Ca	tonsvi	ille							1 ☐ Yes 2 反 No
	or 28	Directo	10e. Street and Number				10f. Zip (en of What Co	-
	eath v	Funeral	912 S. Rolling		dent Ever in U.S	S. 13. V		1228 ent of His		gin? (Spe	cify Yes or No- Rican, etc.)		goslavi	
٥	hours after death with the Maryland tural; or ttems 23a or 28a-f show at Exeminer must be malitled at	/ Fun	1 Never Married 2 Marrie	Armed Ford 1 Tes :	2 🔀 No		f Yes, specif 1 ☐ Yes 2		n, Mexican Specify:	i, Puerto	Rican, etc.)		Black, White Specify: To	te, etc. Vhite
9500-51212	n 72 hours after death with the Marylan "natural", or flems 23a or 28a-f show adical Exeminer man be maillied at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Da	tes:	16a Dece	lent's Usual	Occupa	ition				nd of Business	
<u>دا ۲</u>	filed within 72 Hygiene. Ither then "nat	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-	4or 5+)	(Give life.	kind of work DO NOT use	done d retired)	luring most)	t of worki	ng			·
	filed within Hygiene ther then int, it e M	Co	12 17. Father's Name (First, Middle, L	est)		Clot	hing I	Desi		er's Name	(First, Middle,		Clothin	ng
_	~ - 0 =	To Be	Nicola Jole								ojanov			
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny Injury or other traumatic ev pdes.		19a. Informant's Name/Relationshi Nicholas A. Jole		Can						I Route Numbe			Zip Code)
رة ح	1 and Health em 27 ither tr		20a. Method of Disposition		Son	ace of Dispo	sition (Name	e of	1		ershey,		17033 cation - City or	Town, State
Ē	Pages ent of nt: If It ry or o		1 Burial 2 Cremation 3 Other (Spe		state	emetery, crer Laney	•	,	· 1	11/14	/2006	Fimor	nium. M	laryland
Baltimore,	ermit. epartir nports ny inju		21. Signature of Funeral Service Li	cense	0				one o	y Ste	rling A	Ashto	n Schw	wab Witzke MD 21228
	40 E 5 d		23a. Part1. Enter the disease, or o	omplications that ca	used the death								sville,	Approximate
	Physician		shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on ea	Ich line.		re t				, ,			Interval Between Onset and Death
Mar.	/Medical Examiner		resulting in death)	a. Due to (c	or as a consequ	ience of):	, ()	0 1	- WILL	VC				111101119
*.	LAdminer	<u>ت</u>	Sequentially list conditions, if any, leading to immediate	b. Va	SCULCU or as a consequ	ience of):	mer	170	તે					
1	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
	ate be exacuted hysicien and the burial-transit	cal Ex	resulting in death) Last	Due to (d	or as a consequ	ience of):								
68/6L	0 0		9	d										
		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		rth 2 ☐ Fetal	death 3	Ectopic pre					2	3d. Date of de	livery Day Year
0	at the dea by the at tached fo	yslcl	1 Yes 2 No	4□Pregna 9□ Unkno	ant at time of de wn	eath 5	Other (spe	ecify)					1001111	
ο, J	law requires that the death as been signed by the atter 2 should be detached for u	by Ph	Part II. Other significant condition	s contributing to de	ath but not resu	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	obacco us	se contribute t	o the cause of death?
ecords,	w require been sig should b		Aspiration Pr	Cumoni	a						1 🗆 Y	/es 2[]No 3∏P	robably 4 ⊉€nknown
Kec	The law ate has b bage 2 sl	Completed										sy rmed?	prior to death?	utopsy findings available completion of cause of
_		Be Co	25. Was case referred to medical						26. Place	of Death	1 Yes	2 E No	1 🗆 Yes	s 2 No
> tc	£ 5 6	၉	examiner? 1 Yes 2 No			ER/Outpatier			414040		me 5 Resid			əcify)
0	rding f th. : After s funer	ıtlon	27. Manner of Death 1		n, Day Year)	28b. Time of Injury	M Z	Sc. Injury Work	rai ?? Yes 2 🔲		28d. Describe h	low injury	Occurred	
Division of	r Atter ter dea rector by the	Certification:	3 Suicide 6 Could no 4 Homicide determin	286. Place	of Injury - At ho	me, farm, str	eet, factory,	office			28f. Location (S City or Tow			ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying	Physician: To the	hest of my know	wledne deat	n occurred a	it the tim	e date an	nd place :	and due to the	causa(s)	and manner a	hateta a
	ne Hos ne Fun sietely	Medical		xaminer: On the ba and mann	sis of examinat									
	withii To th	Σ	29b. Signatur and title of certifier						number				e signed (Mon	
,	\cap		30. Name and address of person w	to completed cause	of death (Item	23a) /Tune	Print\	459	101			NO	12	,2006
	1		Dobrah P	orce.	7230	Par	CHE	ghil	2 AN	one	u Bo	alt	more	,2006 MO 21208
4000	Sta Registi		31. Date filed (Month, Day, Year)	4	gistrar's Signal	ture	- Sel	5						
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	100	MOV 1 5	2006	FREE RELIEF	CA SEE	DATA CALL							

		For Stata Registrar	State of M	-	epartment of Certificate		nd Mental Hy	giene Reg. No2 0 0	5 36161
Physicia		1. Decedent's Name (First, Middle Salvatore Sa					2. Date of De Month Novemb	Day Ye	
/Medic Examin		4a. Facility Name (If not institution,	give street and number	-)	4b. City, Tov	n, or Location of		4c. County of D	
		Manor Care-		(1 11 6-46-		WSON	4 Hrs. Lo. D (Di-	Baltir	
Funeral Director		5. Social Security Number 217-38-8968	6. Sex 7. A	ge (In yrs. last birtho	Months D	ays Hours	4 Hrs. 8. Date of Bin (Month, Da 7 – 1 9 – 1	ıy, Year)	Birthplace (State or Foreign Country)
		Usual Residence of Decedent		10c. City, Town o	al casting		1		10d. Inside City Limits
Aaryla f shov	ō	MD Balt:	imore		keysvil	le			1 ☐ Yes 2X No
r 28e-	Director	10e. Street and Number			10f. Zip Co			10g. Citizen of What	Country?
th with	al D	2 Montvieu (Court		Balt	imore		USA	
er dea Items	Funeral	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S.	13. Was Decedent If Yes, specify	of Hispanic Origi Cuban, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
If a rail of the Maryland filed within the Maryland Hygiene. Hygiene. Hygiene. Interthan 'naturel' or Items 23a or 28e-f show ant, the Madical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Marri 3 🔯 Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 🔯 If Yes, Give Year or Dates:		1 □ Yes 2 % □	No Specify:		Specify: W	hite
72 ho	Completed	15. Decedent' (Specify only highes		16a. D	ecedent's Usual O Give kind of work of fe. DO NOT use re	ccupation lone during most of	of working	16b. Kind of Busine	ss/Industry
within within then.	dmo	Elementary/Secondary (0-12)	College (1-4or	(5+)	fe. DO NOT use n ailor	etired)	-	Jos. A.	Bank
Hygie other	a	12th 17. Father's Name (First, Middle, L	.ast)			18. Mother's	s Name (First, Middle,		Dank
lal ylallu 6.16. 2 should be filed within and Mental Hygiene. Is marked other than eumetic event, the Mental and Mental and and a second a second and a second and a second and a second and a second an	To B	Giuseppe Sac				Gra	acia Vinc	i	
2 sho 2 sho 1 and 1 1s ma reume	·	19a. Informant's Name/Relationsh					or Rural Route Numbe		
ie, mai ylaina 212 s 1 and 2 should be filed within theath and whental thygiene. tiem 25 a marked other than other treumetic event, the M		Massimo Sacca 20a. Method of Disposition	ì	20b. Place of D	isposition (Name of	of !	Cockeysv	ille, MD 20c. Location - City	
0 O		1 ⊠Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		comptoni	crematory or other	r place)	1/16/06	Baltimor	
Dealthings, in permit, Pages 1 and Department of Health Importent: if item 27 eny injury or other troops.		21. Signature of Funeral Service L			22. Name and A	ddress of Facility		. Zannin	o Jr. FH
		23a. Part1. Enter the disease, or shock, or heart failure. List	omplications that cause	ed the death. Do not					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	- 15		structiv	~ Luc	DiJease		Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	s a consequence of)					7
	e	Sequentially list conditions, if any, leading to immediate cause. Enter in denying Cause (Disease or injury	b. Due to (or as	s a consequence of):					-
cuted	Examiner	that initiated events	с						
ate be executed hysician and the burial-transit	EX	resulting in death) Last	Due to (or as	s a consequence of):					
icate t	edlcal		d						
h certif	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Fetal death	3 Ectopic pregn	2001		23d. Date of	delivery
ires that the death certific signed by the attending p b detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death	5 ☐ Other (specif			Month	Day Year
that the ed by detacl		Part II. Other significant conditio	ns contributing to death!	but not resulting in th	e underlying caus	e given in Part I.	23e. Did to	obacco use contribute	to the cause of death?
quires no sign	ed by					_	101	Yes 2□No 3	Probably 4 Unknown
law requir as been si	Completed						24a. Was		autopsy findings available to completion of cause of
The The cate h	Соп							rmed? death 2No 1□Y	?
VILC Sicien certifi irector	o Be	25. Was case referred to medical examiner?	Hospital:			0.1	f Death (Check only o		
eraldi	H- 1	27. Manner of Death	28a. Date of Inju			4 ∟¶svurs Injury at Work?	ing Home 5 Resid	dence 6 Other (S now injury occurred	pecify)
ending sath. or: Aft	atlo	1 Natural 5 Pending 2 Accident investig	ation	ay Year) Inju		1 ☐ Yes 2 ☐ No			
I or Att	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Place of in	njury - At home, farm tc. (Specify)	, street, factory, of	fice	28f. Location (5 City or Tox	Street and Number or vn, State)	Rural Route Number,
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel birector: Attentians certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier 1 ertifying (Check only one)	g Physician: To the best examiner: On the basis of and manner st	of examination and/o	eath occurred at the rinvestigation, in a	ne time, date and my opinion, death	place, and due to the occurred at the time,	cause(s) and manner date and place, and c	as stated. ue to the cause(s)
To the within To the Comple	Me	29b. Signat and title of certifier	10	4.		cense number		29d. Date signed (Mo	onth, Day, Year)
2		1 Jana 18	as in	0	1	006119	9	NOV. 14.	2006
2		30. Name and address of person v	who completed cause of	death (Item 23a) (Ty	pe, Print)	0+ 1	1 200	7	mD 21204
	•	Jason Black &	32. Regist	trar's Signature	her les	١٠ ا ١	11re 207,	wison	mD 21207
Sta Registr		NOV 1 5		ion Be	Contin				

DHMH 17 Rev 1/2001

			For State Registrar	State of M	arylan		artment			and Me		giene	2006	36	162
			Decedent's Name (First, Middle, I	Last)						1:	2. Date of Dea	ith	_000	3. Time o	f Death
1	Physici		Frederic Ric	chard Stru	ıb					, n	Month Novembe	Day r 1	Year 1 2006	7:05	, M
	/Medic Examin		4a. Facility Name (If not institution, o	give street and number)		4b. City,	Town, or	Location o		TO V CILLD C		County of Dea)A
	LAdilli	CI	Casey House				D	oakıı	ille			,	ontgom	erv	
	Funeral			. Sex 7. Ag	ge (In yrs.	last birthday)	If Under	1 Year	If Under 2		B. Date of Birtl	h	9. Bit	thplace (State	or Foreign
	Director		577-48-8919	1 X□M 2□F	69	Yrs.	Months	Days	Hours	Min.	(Month, Da)			ountry) Lbama	
	ס		Usual Residence of Decedent												
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	
	e Ma	cto	MD Howard	d	H	Ighlan	d							1 L Yes	2 ∑ No
	or 28	Sre Pre	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What C	ountry?	
	72 hours after death with the Maryland naturel', or Iteme 23a or 28a-f ehow ileal Examinar must be indiffed at	Funeral Director	7017 Deer Valle	ey Road				2077	7				USA		
	r dea	ne l	11. Marital Status	12. Was Decedent Armed Forces	2	.S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spec i, Puerto R	fy Yes or No- ican, etc.)	1	4. Race - Am Black, Whi		
98	or II	Y.	1 Never Married 2 Marned	If Yes, Give	No 19	00-	1□Yes 2		Specify:			-	Specify: Wh		
8	urel	d by	3 Widowed 4 Divorced	Year or Dates:											
7	nat	Completed	15. Decedent's (Specify only highest of	Education grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	k done d	ition <i>luring m</i> ost	of working	9	16b. Kin	d of Business	s/Industry	
12	withir then	E G	Elementary/Secondary (0-12)	College (1-4or	5+)							IIS	Gover	nment	
7	Hygie ther nt,		12th 17. Father's Name (First, Middle, La	st) 4		Sen:	ior Ex	xecu		r's Name (First, Middle,			IIIICIIC	
an	2 should be f and Mental H is marked of reumatic eve	Be c	Norbert Stru						Ann			zala			
2	d Me mark matik	၉	19a. Informant's Name/Relationship			19b Mailir	ng Address	(Street a			Route Numbe			Zin Codel	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 is marked other then "naturel", or iteme 23a or 28a-f show other treumatic event, the Medical Examinar transities and life and lifed at		Linda Jennings/								Highla			777	
a)	Heal Heal		20a. Method of Disposition	oudgireer.	20b. P	lace of Dispo				Da			ation - City or		
Baltimore,	permit. Pages 'Department of Himportent: If Ite eny Injury or of once.		X⊠ Burial 2 ☐ Cremation 3		,	emetery, crer Louis				1/15/	(2006				
量	if. P.		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice		56						2006			ome, P.	7
Ba	Dermi Depa Impo eny l		(38)		100770						Laure				Α.
			23a. Part1. Enter the disease, price										207	Approxima	te
			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each I	ine.	55 1151 5111	or the mode	or ayan	g, 500m a5	0414140 01	rospiratory an	030,		Interval Be Onset and	tween
	Pnysician /Medical		disease or condition resulting in death)	a		Cancer									
	Examiner			Due to (or as	a conseq	uence of):									
		70	Sequentially list conditions,	b. Due to (or as	s a conseq	uence of):									
1	nsit	듣	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
	al-tra	Examine	that initiated events resulting in death) Last	c. Due to (or as	s a conseq	uence of):									
8760,	death certificate be executed e ettending physicien and nd for use as the burial-transit	cal		4											
89	ficate p phy is the	ğ		u											
Box	leath certifica ettending ph i for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			_					2	3d. Date of de	livery	
Ď	d for	Ca	in the past 12 months? 1 □ Yes 2 □ No	1 ∐Live birth 4 ☐ Pregnant a			Ectopic pre Other (spe						Month	Day	Year
P.O.	at the de by the	hys	9 Unknown	9□ Unknown											
	g g g	by P	Part II. Other significant conditions	s contributing to death t	but not res	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco us	se contribute t	o the cause of	death?
Vital Records,	w requires been sign should be										1 🗆 Y	es 2]No 3 ☐ P	robably 4 🖔	Unknown
8	aw res	Completed									24a. Was		24b. Were a	utopsy findings	available
æ	The la	E									autop	med?	prior to death? 1 ☐ Yes	completion of (cause of
tal		0	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes Check only o	2 th No	1 🗆 10:	s ZEFNO	
>	Physicien: this certific ral director,	0 B	examiner? 1 ☐ Yes 2 No	Hospital: ↑ ☐ Inpati	ient 2 🗆	ER/Outpatier	nt 3 DO	A Othe					(XOther (Soc	ecity) Hosp.	ice
10	g Ph er th	ä	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of		Bc. Injury Work			d. Describe h			,, nobp	200
Ö	Attending I r death. ector: After by the funer	atle	1 Accident 5 ☐ Pending 2 ☐ Accident investigat		ay rear)	Injury	М		res 2 🗆 f	No					
Division	Atte	2	3 ☐ Suicide 6 ☐ Could no determine		jury - At ho	ome, farm, str	eet, factory	, office		28	3f. Location (S City or Tow	treet and	Number or R	lural Route Nun	nber,
ā	s afte	Certification:		building, 6	to. (Opeon	"					ony or row	n, olulo)			
	Hospital		29a. Certifier 14 Certifying	Physician: To the best	of my kno	wiedge, deati	n occurred a	at the tim	e, date and	d place, ar	d due to the	ause(s)	and manner a	s stated.	-1
	he H in 24 he F plete	edical	one)	taminer: On the basis of and manner si	tated.	tion and/or in	vestigation,	in my op	mion, dear	in occurred	at the time, t	ate and	piace, and du	e to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Σ	29b. Signature and title of certifier	-					number		;	29d. Date	signed (Mon	th, Day, Year)	
•			Cynthia n	1 milles.	mo	Do		HOC	1580	32		Nov	vember	12, 20	06
	a		30. Name and address of person wh		death (Iten										
	_[Cynthia M. Wil				1 Mun	cast	er Mi	lll Re	oad, Ro	ockvi	ille, M	1D	
	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture	6. 3								
	Registr	ar	NOV 1 5 200	6 1819,20	Laso	SPOSIN	B. A.								

Certificate of Death

Physici /Media Exami

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28s-f show eny injury or other treumatic event, the Madical Examinar must be notified at ORGE.

Baltimore, Maryland 21215-0036

Pnysician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Registrar		Hillical	e or L	Jeani			Reg. No). 		,
n	Decedent's Name (First, Middle, Last) PATRICIA BURSLEY STRA	ADLEY					2. Date of De Month Novemb	ath Da	y 20	Year 0.6	3. Time of Death 10:50 pM
ıl			45 035	T	1						<u> </u>
r	4a. Facility Name (<i>If not institution, give street and number,</i> Laurel Regional Hospital			lown.or urel	Location	of Death			County rinc		eorge's
	5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthda		r 1 Year	If Under		8. Date of Bit	th	,	9. Birth	nplace (State or Foreign
	577-32-5804 1 M 2 XX	79 Yrs.	Months	Days	Hours	Min.	(Month, Da Dec. 2	4. Tear,	926	Ohi	uintry)
1	Usual Residence of Decedent										
-	10a. State 10b. County	10c. City, Town or	Location								10d. Inside City Limits
io.	Maryland Montgomery	Burtons	ville								1 ☐ Yes 2 ☐ No
Dire	10e. Street and Number		10f. Zi	p Code				10g. Ci	tizen of V	Vhat Co	untry?
œ	15212 Birmingham Drive		2	0866				U.	S.A.		
e	11. Marital Status 12. Was Deceden Armed Forces	Ever in U.S. 13	Mas Dece	dent of Hi	spanic Ori	igin? (Spe	cify Yes or No Rican, etc.))·		e - Amer	ncan Indian,
ᆲ	1 Never Married 2 Married 1 Yes 25			and the							
2	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 🗌 Yes	ALA NO	Specify:				Specify	. Wh	irce
ede	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usu ve kind of wo	al Occupa	ation during mos	t of worki	ng	16b. F	Kind of Bu	siness/l	Industry
Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4or 3 years	5+) //ife	. <i>во мот і</i> ab Tec	ise retired)				Medi	cal	
င်	17. Father's Name (First, Middle, Last)	1 10	ab icc	I		er's Name	(First, Middle				
To Be	Harry Clark Bursley				Eliz	abet	h (unk	nown	.)		
-	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Addres	s (Street a	and Numb	er or Rura	al Route Numb	er, City	or Town,	State, Z	(ip Code)
	James Clarke Stradley / sor					ive	Burto	nsvi	lle,	Mar	yland 20866
	20a. Method of Disposition	20b. Place of Dis cemetery, cr	position (Na	me of	اه	C	ate	20c. L	ocation -	City or	Town, State
	1 ☐ Burial XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	West Arı			1	11	/13/06	Od	ento	n, M	Maryland
	21. Signature of Funeral Service Licensee		² Dona 1	nd Aron	s run	ral	HOme,	P.A.			
	MOC	770	313 I	albo	tt Av	enue	Laur	el,	Mary	lanc	l 20707
	23a. Part1. Enter the disease or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not e	nter the mo	de of dyin	g, such as	cardiac c	or respiratory a	rrest.			Approximate Interval Between
	Immediate Cause (Final	Infarction	n of S	mall	Inte	stin	e & Co	lon			Onset and Death 8 -12 Hrs.
	resulting in death)	s a consequence of):								_	
		eric Arte	cial m	lh rom	hocic						3 - 4 Days
_	Sequentially list conditions, b. Due to (or a	s a consequence of):	LIGI	TIL OIL	DOSTS	,					J 4 Days
in a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence or,									
Examiner	triat initiated events C.										
<u> </u>	Due to (or a	s a consequence of):									
Completed by Physician/Medical	d										
ed											
2	IF FEMALE: 23c. If yes, outcom								23d. Dat	e of deli	very
Cla	in the past 12 months?		B⊟Ectopic p Other (s						Mo	nth	Day Year
Š	1 Yes 2 No 9 Unknown 9 Unknown			,,							
4	Part II. Other significant conditions contributing to death	but not resulting in the	undarkina	cause and	on in Part		23a Did	tobacco	use conti	ribute to	the cause of death?
2	Tartii. Othor significant contains contributing to doubt	but not resulting in the	dilodilying	oause givi	on an an	14					
9							,,,	105 2	: Causes	3 F	obably 4 Unknown
e e							24a. Was		24b. \	Vere au	topsy findings available
Ē								ormed?		death?	completion of cause of
						-	1 Yes	-	0 1	I ☐ Yes	2 (X) No
Be	25. Was case referred to medical examiner?			To:		e of Death	Check only	one/			
0	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Yipat	ient 2 ER/Outpat			4 🗆 141		me 5 Res				cify)
	27. Manner of Death 28a. Date of In (Month, D	ury 28b. Time ay Year) Injun	of	28c. Injun Work	y at k?		28d. Describe	how inju	iry occurr	red	
atc	1 XNatural 5 Pending (Month, D 2 Accident investigation	,,	м		Yes 2	No					
<u> </u>	3 Suicide 6 Could not be 28e. Place of Ir	njury - At home, farm,	street, facto	ry, office						er or Ru	ıral Route Number,
=	4 Homicide determined building, 6	tc. (Specify)	,				City or To	wn, Stat	(e)		
<u> </u>	200 Contillor (X) Contilling Ch.		-45	4.54.0							
Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner s	of examination and/or	ath occurred investigatio	at the tin n, in my o	ne, date ar pinion, dea	nd place, ath occurr	and due to the red at the time.	date an	s) and ma nd place, a	inner as and due	to the cause(s)
ğ	and Comment and title of continue		29	c. License	e number		T	29d. Da	ate signed	d (Monti	h, Day, Year)
_	Nen. L Cer	Sh WE	D			10			-		
				טע	01750	12		NO	vembe	er 9	, 2006
	30. Name and address of person who completed cause of										
	Rene Gelber, M.D. 14201 La	urel Park	Drive	La	urel,	Mar	yland	207	07		
_	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	- M. P								

State

Registrar

5 2006

	•	For State Registrar	State of Maryland		tificate of I			giene U Reg. No.	00	36164
Physic		1. Decedent's Name (First, Middle, Las	Benjamin	Sho	wden		2. Date of Dea	Day	Year 200	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution give		box		Location of Death	NO. C.	1	nty of Death	-
Funeral Director		5. Social Security Number 6. S 1.20 -09-0523		ast birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year) 1922	9. Birthp Cour	lace (State or Foreign try)
pu »		Usual Residence of Decedent 10a. State 10b. County		, Town or Lo	cation				1	0d. Inside City Limits
e Marylan ta-f show	ctor	A/N AM	Bal	timor	e					1 No 2 No
with the	Director	10e. Street and Number	C.		10f. Zip Code			10g. Citizen o	of What Cour	ntry?
r death	Funeral	822 N. Payson 11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto			lace - Amend	
ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Itama 23a or 28a-f show or other traumatic svent, the Medical Examinat	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:		☐ Yes 2.28 No	Specity:		Spec	cify:	cK
72 hou natura	eted	15. Decedent's Ec (Specify only highest gra	ducation de completed)	(Give	ent's Usual Occup	during most of worl	king	16b. Kind of	Business/In	
within liene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Marc	00 NOT use retired CALK	3)	:	Retai	. \	
La y all of the within and Mental Hygiene. Is marked other than aumatic svent, the Manal Hygiene.	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	_		ame)	
2 should and Men is marke	6	19a. Informant's Name/Relationship (19b. Mailin	g Address (Street	ENCL) and Number or Ru	ne ma		vn, State, Zip	Code)
and 2 sealth ar m 27 is		Pateicia M. Shaw	(daughter)	9904	Southal		ndalkte			133
permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any Injury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cren	sition (Name of natory or other place	ce)	Date	140 66	n - City or To	
permit. Pa Departme Important any Injury		*4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		ng Yar		ss of Facility	12006 meeal Su	nonda	16100	שאונחכ
Decrini Depa Impo		Vaugho C.	Grane	Of	DI Palto	NOH P. W	e. Baltim	DEP, M	D 213	Approximate
Physician	ı	23a. Part1. Enter the disease, or com shock, or heart falure. List only Immediate Cause (Final	one cause on each line.		ock	ig, such as cardiac	or respiratory an	11031,		Interval Between Onset and Death 2 weeks
/Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequence)			- (1)-				- 1
Lammer		Sequentially list conditions,	b. Due to or as a conseq		act iv	fection	1			Zweeks
ocuted nd transit	Examiner	Sequentially list conditions, Tary leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c							
be exessicien a		resulting in death) Last	Due to (or as a consequent	ience oi);						
rtificate ng phys	Medical	IF FEMALE:	-							
The Corrus, F.C. BOX 00100, The law requires that the death certificate be executed ale has been signed by the attending physicien and page 2 should be detached for use as the buriat-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	y			Date of delive Month	ery Day Year
w requires that the been signed by should be detail	ρ	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.		obacco use co Yes 2 No		he cause of death?
VICEI DECOTOR sicien: The law require s certificele has been si director, page 2 should is	Completed						24a. Was autoj perfo		prior to co death?	psy findings available impletion of cause of
iclan: Ticlan: Sertificel	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Dea	The second second	one)		
g Phys er this eral dir	n; To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury			ome 5 ☐ Resi 28d. Describe			y)
ttending death. stor: Afte the fune	catio	1, Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	n		M 1 🗆	Yes 2 □ No	29f Leasting /	Ctrant and No	mhor or Pur	al Route Number,
DIOT At after of Direct	Certification;	4 Homicide determined			eet, factory, office		City or To		mber of Hara	a noble raliber,
To the Hospite or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical C		nysicien: To the best of my kno miner: On the basis of examina and manner stated.							
To th within To th comp	Me	29b. Signature and title of certifier	7-110		29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)
0		30. Name and address of person who	completed cause of death /litera	23a) (Tune	Print)	+>1>		- 111	12/60	N (g
1			edlander, M.D.	10 N	Gree	ne St.	reet I	Saltin	yore,	M.D. 2/201
S Regis	tate trar	31. Date filed (Month, Pay, Year)	2006 32. Registrar's Signa	iture	and of				,	M.D. 2/20/

			For State Registrar		State of M	Marylan		artmen rtificat			and M	F	leg. No.	006	36165
	Physicia	an	1. Decedent's Name (F Berniece Le									2. Date of Dea Month Novembe		, 2ŏซ̃6	3. Time of Death 7:50 AM M
*	/Medic Examin	or.	4a. Facility Name (If no Spring Hou	st institution, give	street and number	ng		4b. City,		Location o		ing		tgomer	
i c	Funeral Director		5. Social Security Num 573-34-109	6. Se	9X □ M 2 X F	Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year_ Days	If Under Hours	24 Hrs. Min.	8. Date of Birth 05/9/1/8/	1969	9. Birth MI ^{Coll}	place (State or Foreign intry)
	pug *		Usual Residence of De	ocedent Ob. County		10c. City	y, Town or Lo	cation			-				10d. Inside City Limits
	Manyia	to		Montgome	ry	Sil	ver Sp	ring							1 Yes 2 No
	3a or 28a	i Direc	10e. Street and Number 2201 Colste			1		10f. Zip 209	Code 10-				10g. Citize USA	n ol What Cou	intry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "naturel", or iteme 23a or 28a-f ehow other traumatic event, the Medical Exactinal mark the notified at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	_	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	s? No		Was Deced If Yes, spec	. 4	ispanic Ori in, Mexicar Specify:	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White pecify: Whit	, etc.
21215-0036	within 72 ho ene. then "natur ne Medical I	Completed		5. Decedent's Econly highest gra		2 ⁵⁺⁾		kind of wo DO NOT u	rk done d se retired	during mos	t of worki	ng	16b. Kind Elect	ol Business/l Cronics	ndustry
land 2	2 should be filed within n and Mental Hygiene. 'ie marked other then "raumatic event, in a Men	To Be Co	17. Father's Name (Fin								r's Name Ker	(First, Middle,	Maiden Su	umame)	
Maryland	and 2 shou balth and M n 27 ie mar		19a Informant's Name Michael D.	e/Relationship (Type, Print) on		19b. Mailii 1615	ng Address Manc	S (Street a	and Numbe er La	ne W	al Route Numbe ashingt	or, City or 7	own, State, Z C 2001	ip Code) 1 —
Baltimore,	permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other tra ance.		20a. Method of Dispos 1 Burial 2 0 4 Donation 5	Cremation 3	Removal from Sta	20b. P	Place of Dispo emetery, crei	matory or o	me of other place	2 /		Date 18,2006		ition - City or T	^ .
Balti	permit. Departminimports any inju		21. Signature of Fune	ral Service Licer	see provi	358		apprer 33 Gi:		e. S	remat ilver	ion Ser	vices , Mary	land 20	910-
	Physician per period by some physician pub some physician and pub some period by	icai Examiner	23a. Part1. Enter the shock, or heart findisease or condition resulting in death) Sequentially list condition, leading to imm cause. Enter Underly Cause (Disease or injust initiated events resulting in death) Last	allure. List only nal	a. Park Due to (or b. Due to (or	n ime.	uence of):						1631,		Approximate Interval Between Onset and Death
P.O. Box 68760,	requires that the death certificate be executed required signed by the attending physicien and hould be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 14 9 □ Unknown	onths?		n 2∐Feta itattime ofd	I death 3	⊒Ectopic p □ Other (s _i		,				d. Date of deli Month	Day Year
	w requires that been signed should be de		Part II. Other significant	nt conditions o	ontributing to deal	th but not res	ulting in the u	underlying (cause giv	en in Part	l. 		obacco use		the cause of death? bably 4 Unknown
I Records,	The law ate has b page 2 s	Completed by							-			24a. Was autor perfo 1 Yes		prior to death?	topsy lindings available completion of cause of 2 No
Division of Vital	Attending Physician: The Ir death. croath. sctor: After this certificate hay the funeral director, page	To Be	25. Was case relerred examiner? 1 Yes 250 No. 27. Manner of Death 1 Natural 2 Accident		1		ER/Outpatie 28b. Time o Injury		28c. Injur Wor	ier: 4□N	ursing Ho	h <i>(Ch</i> eck only come 5 ☐ Residente 128d. Describe I	dence 6	Other (Specoccurred	Assisted Living
Divis	al or Atter after des i Director d in by th	Certification:	3 Suicide 4 Homicide	6 Could not be determined	288. Place 0	f Injury - At h j, etc. <i>(Speci</i> i		reet, facto	ry, office			28l. Location (: City or Tox		Number or Ru	ral Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 (Check only 2 one)	Certifying Pl	nysician: To the b miner: On the bas and manne	is of examina	owledge, dea ation and/or in	th occurred nvestigation	d at the tir n, in my o	me, date a pinion, de	nd place, ath occur	and due to the red at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	To th within To th comp	×	29b. Signature and tit	le of certifier						se number			i .	signed (Month	n, Day, Year)
			LINA	~	2				रि	656			11/10	3/06	
	15		Ravi Pas	10 10 10	11 1	of death (Iter	m 23a) (Type	, Print)	04 8	3 51	uen <	pring	mr	209	10
	St. Regist	ate rar	31. Date filed (Month)	311		strar's Sign	ature	Corn	E)			1		V1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.0 C

			1 = For Sitate Registrar	ate of Maryla		partment of H e <i>rtificate of l</i>	lealth and Me <i>Death</i>	entai Hygiei Reg.		36166
	Physici	an	Decedent's Name (First, Middle, Last)					Date of Death	Day 1 Year	3. Time of Death
	/Medic	al	Mildred 4a. Facility Name (If not institution, give stree		nn	Scott 4b. City. Town. or	Location of Death	VOVEMBE	4c. County of Deat	
	Examin	er	To 11.1 C	tospity1		Rosea	Inle	1	Baltime	
	Funeral		5. Social Security Number 6. Sex	a loth r	rs. last birthda 7 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min. 1	Date of Birth (Month, Day, Ye	9. Bird (Co	thplace (State or Foreign
	Director		Usual Residence of Decedent				U	uly 13,1	929 1110	ryland
)	farylar	ŏ	10a. State 10b. County	10c.	City, Town or					10d. Inside City Limits
	1 the N	Director	Maryland Baltimore 10e. Street and Number		Bail	i more		10g.	Citizen of What Co	
	23a o	rai D	8928 Kilkenny Ci	rcle		2123			U.S.A.	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or iteme 23a or 28e-f show aumatic event, the Medical Examinations to could be a coulded.	by Funerail	, , , , , , , , , , , , , , , , , , ,	Vas Decedent Ever ir Armed Forces? I □ Yes 2 1 No If Yes, Give Year or Dates:	1 U.S. 1	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Speci in, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify:	e, etc.
9	2 hour	ted t	15. Decedent's Educatio	on	16a. De	cedent's Usual Occup	ation	16b	. Kind of Business	lite Industry
215	within 72 ene. then "nat	Completed		College (1-4or 5+)	life	. DO NOT use retired				
d 21	Hygier ther ther	e Co	12 17. Father's Name (First, Middle, Last)			Transcribe	18. Mother's Name (Self-Empl (en <i>Suma</i> me)	oyed
Maryland 21215-0036	uid be Mental rrked o	To Be	George Her	mann			Cat	herine	Bonus	
Man	ges 1 end 2 should t of Heelth and Men if Item 27 ie marke or other traumatic		19a. Informant's Name/Relationship (Type, I				and Number or Rural F		1970	
_	Heeltl Heeltl tem 2		Carol S. Green 20a. Method of Disposition	Daughter 201		1 Sunset L. position (Name of rematory or other place		sburg, Ma	Ary land Location - City or	21048 Town, State
Ē	Pages nent of nnt: if it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	Wal II Olf State			orp. 11-15	-2006	Towson	Maryland
Baltimore,	permit. Pages 1 end 2 Department of Heelth s Importent: if teen 27 is eny injury or other tra once.		21. Signature from value service Licensee			22. Name and Addres	ss of Facility Ruc	k Towson		Home, Inc.
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ons that ceused the diuse on each line.	eath. Do not e	enter the mode of dyin	g, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Abdo mi	19/	gortic	91201	75m		
ı	Examiner		Facuartially list conditions b	LUNG	0	cel		,		
	pe als	iner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a cons	-		-1 - V			
₩ <u></u>	execut n and ial-tran	Examiner	that initiated events c	Due to or all a cons	sequence of):	mic	Shock			
68760,	icate be executed physicien and s the burial-transit	edicai	d							
39 ×	certifica ding pl		IF FEMALE: 23c. II	f yes, outcome of pre	onancy				224 8-4-44	
Division of Vital Records, P.O. Box	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Completed by Physician/M	in the past 12 months?	1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death	B Ectopic pregnancy Discrete (Specify)			23d. Date of del Month	rvery Day Year
ds, P	signed b	d by Pł	Part II. Other significant conditions contribu	uting to death but not	4	underlying cause give		11		the cause of death?
COL	s been s shou	ojete		1				24a. Was an	24b. Were au	itopsy findings available
E Be	The la	Com						autopsy performed 1 Yes 2	? death? No 1 Yes	completion of cause of 2 No
Vita Vita	sicien: certific rector.	Be	25. Was case referred to medical examiner?	ital: 🛰		tent 3 DOA Othe	26. Place of Death (Check only one)		
ō	g Phys er this eral di	ը: 1	27. Manner of Death 2	8a. Date of Injury (Month, Day Year	28b. Time Injun	of 28c, Injury	4 1 I I I I I I I I I I I I I I I I I I	 5 ☐ Residence d. Describe how in 		cify)
Sior	eath. or: Aft	catio	1/⊠Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1	Yes 2 □ No			
<u>N</u>	after d after d Direct	Certification;	4 Homicide determined	8e. Place of Injury - A building, etc. (Spe	it home, farm, ecify)	street, factory, office	28	f. Location (Street City or Town, St	and Number or Ru ate)	ıral Route Number,
_	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one) Check only one)	in: To the best of my line of the basis of exame and manner stated.	knowledge, de ination and/or	ath occurred at the tim investigation, in my or	ne, date and place, and pinion, death occurred	d due to the cause at the time, date a	(s) and manner as and place, and due	stated, to the cause(s)
	To the within (To the	Mec	29b. Signature and title of certifier	and mailler stated.		29c. License	e number	29d. I	Date signed (Mont	h, Day, Year)
)	i		1 Abra, MI	2		RE.	5000	No	rember.	10,2006
	H		30. Name and address of person who comple				12. 14	0 3/22		
	Sta	te	31. Date filed (Month, Day, Year) NOV 1 5 2006	32. Registrar's Si	gnature		imon M	1, 2(25		
4	Registr		NUV 1 5 2006	1 Paging	E.	Charles				

			1 For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of l			000	2010
B	Dhusis		Decedent's Name (First, Middle, Last	it)			2000	2. Date of Death		3. Time of Death
	Physic /Medi		Walter	J.	Szymanski			November	Day Year 12,2006	9:47 A M
	Exami	ner	4a. Facility Name (If not institution, give	,			or Location of Deatl	n	4c. County of Dea	
	Funeral		Gilchrist Ce 5. Social Security Number 6. S		e (In yrs. last birthday,	I OWS	If Under 24 Hrs.	8. Date of Birth	Balti 9. Bi	more rthplace (State or Foreign
	Director		Usual Residence of Decedent	© M 2□F	81 Yrs.	Months Days	Hours Min.	Sept. 23		Maryland
	lanylar show ed at	2	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be notified at	recto	Maryland Baltime	ore	Towson	10f. Zip Code		10	g. Citizen of What C	1 Yes 2 No
	h with 23a or st be	al Di	205 E. Joppa Ro	oad Unit	706		286	10	U.S.A	•
	r dear	ner	11. Marital Status	12. Was Decedent 8 Armed Forces?			Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No-	14. Race - Am Black, Whi	erican Indian,
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral Director	1 ☐ Never Married	1 Y □Yes 2□N If Yes, Give 1 9 Year or Dates:	44-1946	1□Yes 2□XNo		o riisari, sto./	Specify:	White
15-(n 72 h "natu edica	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wor	kina	6b. Kind of Business	•
2121	withi jiene. r than the M	E O	Elementary/Secondary (0-12)	College (1-4or 5	+) _	wner	ru)		Dry Clean Machinery	•
pu	al Hyg I other vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, Ma		Company
ylaı	ould b Ments arked atic e	To I			manski		Anna			
Maryland	12sh hand 7ism traum		19a. Informant's Name/Relationship (7	,, ,					City or Town, State,	Zip Code)
	Healt Healt tem 2	-	Emma L. Szymans 20a. Method of Disposition	"	20b. Place of Dispo	sition (Name of	a Road Un		Towson, Ma	aryland 2128
JOE	Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cre	matory or other pla	· i		,	,
Baltimore,	permit. I Departm Importar any injur		21. Signature of Unocal Service Licen		Hilltop S	2. Name and Addre			Towson n Funeral	Maryland Home, Inc.
m	o a m o		Haw W Has	an		1050 York		Towson, I		21204
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	lications that caused one cause on each lin	the death. Do not en	ter the mode of dyi	ng, such as cardiac			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Larry	ngen	Conce				Onset and Death
1	/Medical Examiner		To and the second secon	Due to (or as a	a contequence of):					J
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	ficate be executed physician and streem is the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
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Box (The law requires that the death certific tte has been signed by the attending p tage 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p	of pregnancy				00d D-t(d-	
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at		Ectopic pregnanc Other (specify)	у		23d. Date of de Month	Day Year
P.0	that the de ned by the a detached	hys	9 Unknown	9□Unknown						
	iires tha signed d be det	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	nderlying cause giv	en in Part I.	V^		the cause of death?
Sor	w requir been s should	eted						1 (3) Wes	2 No 3 P	robably 4 ∏Unknown
Records,	The lav	Completed						24a. Was an autopsy performe	nrior to	utopsy findings available completion of cause of
or Vital		Be Co	25. Was case referred to medical				26 Place of Dead	performe 1 Yes 2.	No 1 ☐ Yes	2 □ No
<u>-</u>	S	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 🔲 Inpatier	nt 2 ER/Outpatien	t 3 DOA Oth			ce Other (Spe	city) mospice
o u			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	y 28b. Time of Injury	28c. Injur Wor		28d. Describe how		5.17
Division	or Attending after death. Director; Afte in by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	28e Place of inju	ry - At home, farm, str		Yes 2 □ No	000 1	· =	
<u>≥</u>	after after Direct	Certification:	4 ☐ Homicide determined	building, etc.	. (Specify)	eet, lactory, office		City or Town, S	et and Number or Ri State)	ural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	rsician: To the best of iner: On the basis of and manner state	f my knowledge, death examination and/or in	n occurred at the til vestigation, in my o	me, date and place, opinion, death occur	and due to the cau	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Algnature and title of certifier	mailler stat		29e Licens	e number	29d	. Date signed (Mont	h, Day, Year)
			Marin	2		J)S	8303	N	Vimber	13 2000
	12+1		30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Type,	Print)	C1- T	SON MO	C 12 0 : 1	
			31. Date filed (Month, Day, Year)	32. Registra	300 . 4	herles	or love.	N MI)	214	
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State Registrar



DHIVIT 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year Theodore Szczepankowski NOVEMBER 12, 2006 2:05 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NAME KNOWN TO PHYSICIAN: SZCZEPANKOWSKI, THEODORE VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 2 🗆 F Director 154-16-9402 84 10-6-1922 NJ Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes 2 ĂNo FL Broward Margate Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 23a death 2902 NW 64th Terrace Funeral 33063 USA на На На 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ▼QYes 2 No 11 Yes, Give Year or Dates 5/43-46 1 Never Married 2 Married ŏ 1 Yes XX No ģ Specify Specify: 3XXWidowed 4 □ Divorced White natural Completed other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Textile Worker Textile 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Impertant: if item 27 is marked oth any injury or other traumatic event QDGS. 18. Mother's Name (First, Middle, Maiden Sumame, Be ဂ Adolph Szczepankowski Victoria Puzio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Szczepankowski 1976 Colora Rd, Colora, MD 21917-1533 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ICC remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 11-14-2006 Baltimore, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Fink Funeral Home, P.A. M01148 K. Gregory Kink 426 Crain Hwy S, Glen Burnie, MD 23a. Part I Enter the dileasy, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail inc. hist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC OBSTRUCTIVE PULMONARY DISEASE UNKNOWN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine I-transit The law requires that the death certificate be executed and Due to (or as a consequence of). Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 TYes 2 □ No 3 ☐ Probably 4 XUnknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? cate has l 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes · 2X No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1X Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: within 24 hours after de: To the Funeral Directo completely filled in by th 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7 Mar mD 11-12-2006 Jrangi 01010580281 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)
NOV 1 5 2006

JIANYI, ZHANG M.D.,

VA MARYLAND HEATH CARE SYSTEM, PERRY POINT, MD. 21902

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hyg	. 9	\cap	\cap	
State of Maryland / Department of Health and Mental Hyd	iono/	1 1	1 1	300
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		1 - For Stata Registrar	State of Maryland /		f Health and M	Mental Hygie	ne2006	36169
Physi	cian	Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	No. Day Year	3. Time of Death
/Med Exam	lical	Eleanora 4a. Facility Name (If not institution, give s Bel Air Health & Rem			ker m, or Location of Death		2 2006 4c. County of Death	1
Funera Directo		5. Social Security Number 6. Sex 215-28-3331		irthday) If Under 1 Y Yrs. Months Da	ear If Under 24 Hrs. Hys Hours Min.	8. Date of Birth (Month, Day, Ye)		pplace (State or Foreign untry) VA
Maryland I-f show	tor	Usual Residence of Decedent	*	wn or Location				10d. Inside City Limits 1 ☐ Yes 2 🖔 No
h with the 23a or 28s	Funeral Director	10e. Street and Number 912 Fallen Stone	Court	10f. Zip Coo	21014	10g.	Citizen of What Cou	•
aryland 21215-0036 should be filled within 72 hours after death with the Maryland ad Manial Hygiene. marked other then "neturel", or Itams 23a or 28s-f show imatic event, the Madical Exemples.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent If Yes, specify (of Hispanic Origin? (Sp Cuban, Mexican, Puerto No <i>Specify:</i>	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: B	
1215-0 vithin 72 ho ne. hen "netur e Medical i	Completed	15. Decedent's Educ (Specify only highest grade	College (1-40r 5+)		ccupation one during most of work tired)		o. Kind of Business/li	
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Mg Ith a 175 27 is		19a. Informant's Name/Relationship (Type James E. Tucker	ne, Print) 191 C-Brother 9.	12 Faller	reet and Number or Rui n Stone Co	ral Route Number, Ci	ity or Town, State, Zi	
Baltimore, permit. Pages 1 ar Department of Hea Important: if item eny injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Arbu	of Disposition (Name of Pry, crematory or other tus Memor	ial 11/	Date 200 18/06 Ar	butus, M	
Depare			monds	4300 Wa	dress of Facility F/H West absh Ave,			21215
Physician /Medica Examine		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a consequence	Dem	eh Ha	or respiratory arrest,		Approximate Interval Between Opset and Death
68760, Editioate be executed g physicien and as the burial-transit	cai	resulting in death) Last	Due to (or as a consequence	of):				
Geath cert death cert e attendin od for use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	bc. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 ☐ Ectopic pregna 5 ☐ Other (specify			23d. Date of deliv Month	rery Day Year
	ed by PI	Part II. Other significant conditions cont	tributing to death but not resulting	in the underlying cause	given in Part I.	23e. Oid tobacc	co use contribute to t	
The lav	Completed		6.60,-0.	100-		24a. Was an autopsy performed 1 Yes 2/1	prior to co death?	opsy findings available ompletion of cause of
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DIVISION OF To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)			City or Town, Si		
the Hosp nin 24 hou the Fune	Medical	one)	ician: To the best of my knowledger: On the basis of examination are and manner stated.	nd/or investigation, in m	ny opinion, death occur	red at the time, date	and place, and due to	o the cause(s)
		29b. Signature and title of certifier	りろ		Y652	1 -	Date signed (Month,	
3		30. Name and address of person who con Scoth Itas will	1 2 North	(Type, Print) AVIAUI	4652 Bil Air	Mary land	1 210	14
S Regis	tate trar	31. Date filed (Month, Day, Year) NOV 1 5 2006	32. Registrar's Signature	berli		/		

Please Type or Print in Black Indelible Ink

Jenn	ald Thome		State Of Maryland / D 1-For State Registrar	Certificate o		id Wichtai Fry		g. No. 200	6 3617
Mod	Physici ical Exami	an/	Decedent's Name (First, Middle,Last)				2. Date of Deatl Month October 30		3. Time of Death 0402 hrs
wea	icai Exami	пег	Bernard Lee Thorne 4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	r Location of Death	October 30), 2006 4c. County of Death	
			Shady Grove Adventist Hospital		Rockville			Montgomery	
	Funeral Director		579-80-2022 1XM 2_F 4	n yrs. last birthday) 7 Yrs	If Under 1 Ye Months Day s.		8 Date of Birt Feb. 3	h(MM/DD/YYYY) 9. Bir Foreig Co	thplace (State or grWash . D.C. untry)
	any		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Loca	tion			-	10d. Inside City Limits
		-	Maryland Montgomery	Germantow	n				1 X Yes 2 No
	Maryla 28a-f d at or	Director	10e. Street and Number		10f. Zip Code			g. Citizen of What Cou	
	ith the Maryland 23a or 28a-f show a notified at once.		3 Duck Pond Court		20874			United Stat	
	ter death w ", or items er must be	y Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces? 1 Yes 2 X 3 Widowed 4 Divorced If Yes, Give Year	No If Y		ispanic Origin? (Spent) in, Mexican, Puerto I o specify:		White, etc.	American
	hours at natural Examin	ed by	15. Decedent's Education (Specify only highest grade complet	ed) 16a Decede		ation (Give kind of w e. DO NOT use retire		16b. Kind of Business/	Industry
	36 nin 72 l e. thau ", dieal F	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Barbe			,	Tonsorial	Care
	(D 21215-0036 should be filed within 72 and Mental Hygiene. 7 is marked other thau 'natie event, the Medical	Com	17. Father's Name (First, Middle, Last)	Bulb		18.Mother's Name	(First, Middle, M	laiden Surname)	
	121 d be fill fental P arked arked	B	Leroy Thorne	1401-14-7	A 1.11	Gillise			
	, MD 2121 and 2 should be fi ealth and Mental tem 27 is marked traumatic event.	오	19a. Informant's Name/Relationship (Type, Print) Ashley M. Thorne (daughter)					ber, City or Town, State ${ t shington,\ I}$	
	e, N 1 and 2 Health Fitem 3		20a. Method of Disposition	20b. Place of Dispo- crematory or of	sition (Name of ce		Date	20c. Location - City or	
	More Pages 1 nent of H ant: If it		1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	Washington		al 11/	14/06	Suitland,	Maryland
	Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati	İ	21 Signature of F. n. ral Service Licensee					uneral Serv	
	Physician		23a. Part I. Enter the disease, or complications that caused the					ash. D.C.	20012 Approximate Interval
	/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) The failure is a consequence or condition resulting in death) The failure is a consequence or each line.		ion ase				Between Onset and Death
		_	Sequentially list conditions, if any, leading to immediate b Due to (or as a consequence)	ance of):					
		Examiner	Cause. Enter Underlying Cause. (Disease or injury that initiated						
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	eco he law ate has age 2 s	дшо					perform	med? death?	
	Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical examiner?		26.Plac	e of Death (Check o	nly one)		
	f Vit Physic er this ral dire	유	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 28a Date of Injury	2 ✓ ER/Outpatien 28b Time of				Residence 6 Other	·:
	on of value of value of value of the control of the	ertification:	Month, Day, Year) Pending Accident Investigation Thd 10/30/2		1	Yes 2 v No	unknown		
	ivisior or Attend after death Director:	ifica	Z /Yourdelle illivestigation	- At home, farm, stre		building, etc		treet and Number of Ru ate) 3 DUCK Pon	ral Route Number, City
	Divi	Cert	4 Homicide determined (Specify) foun	d in reside	nce		Germanto	wn, MD	
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ledical	29a Certifier (Check only one) 2 Medical Examiner: On the best of my known and manner stated		ation, in my opinio	n, death occurred at		and place, and due to th	e cause(s)
		Σ	29b. Signature and title of certifier		29c Licen			29d. Date signed (Mo.	
			Musica Masaull MS 30 Nameland address of person who completed cause of death	(Item 23a)		.M.E. 		October 30, 2006	
	17		Melissa Brassell, MD Assistant Medical Ex		Penn Street, I	Baltimore, MD 2	21201		
		tate	31. Date filed (Month, Day, Year) NOV 1 5 2006 32. egistrar's S	ignature	will !				
	Regis	trar	HOLT O FOR	The same	111 1975				

			1- For State of Maryland / Dep	artment of Health and Mertificate of Death	lental Hygien Reg. N	/ 1116 361/1
			Decedent's Name (First, Middle, Last)	,	2. Date of Death	3. Time of Death
	Physici /Medio		Louise J. Terzigni		November	14,06 12:23a ^M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
			3818 Marcus Court	Monkton If Under 1 Year If Under 24 Hrs.		Harford
	Funeral Director		5. Social Security Number 6. Sex 1 M 280 F 7. Age (In yrs. last birthday 1 M 280 F 92 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 1 2 / 2 0 / 1 9	9. Birthplace (State or Foreign Country) New York
	/land		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Many e-f eh	tor	MD Harford Monkton	ו		1 ☐ Yes 2 🛣 No
	a or 28	I Direc	10e. Street and Number 3818 Marcus Court	10f. Zip Code 21111	10g. C	Citizen of What Country?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28e-f ehow any injury or other traumatic event, it a Medical Exaction rust be notified at ODGE.	Funeral Director		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	ural', or	þ	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 21② No Specify:		Specify: White
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	e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	on Sumame)
ylaı	Menta	ToE	Salvatore Cuomo		nine Sava	
Maryland	and raum		19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mail			
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JOE L	ages ant of it: if it y or o		TEDUNE E CONTRACTOR O CONTRACTOR STATE	matory or other place)		nonium, MARYLAND
Baltimore,	mit. Postme			ey Valley (11/18) 2. Name and Address of Facility Jos		
ä	g 9 ft e 9		Maria P. Jannero	263 S. Conkling	St.Balti	more, MD 21224
			23a. Part1. Enter the disease, of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac of	r respiratory arrest,	Approximate Interval Between Onset and Death
å	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	and competel	-	Silset and Deali
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u C	i or Attending Physician: The i effer death. Director: Affer this certificete ha i in by the funeral director, page	Certification	27. Manner of Death 1 Statural 5 Pending (Month, Day Year) 2 Accident investigation	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
ĮS!	Attending in death. ector: After by the fune	flca	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st		8f. Location (Street a	and Number or Rural Route Number.
á	s effer al Direct ad in by	Cert	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Stai	te)
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	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
~	4		David 5 Du	032255	No.	penher 15, 2006
	0		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	.,	,
	Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signature	hall Below 1	J.B	
	Registr		31. Date filed (Month, Day, Year) NOV 1 5 2006 32. Registrar's Signature	arte		

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Shawn Keith Tille		S I- For State	tate of M	laryland		tment of	Health and	Mental	Hygiene		0.00	6 06171
		Registrar 1. Decedent's Name (First, Mid	ella 1 ant\		Centi	ricate or	Death		2. Date of	Reg. No	200	G Time of Death
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		SHAWN 4a. Facility Name (if not institut				- 4	lb. City, Town, or L	ocation of De			lc. County of Deat	th
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Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. las	t birthday)	If Under 1 Year			f Birth (MN	Forei	irthplace (State or
Director	-	220 25 4252	1X M 2	F	16	Yrs	Months Days	Hours N	Min. NOV	.13,	1989 C	ountry) MD.
	İ	Usual Residence of Decedent			40 00 7							10d, Inside City Limits
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death w	Funeral			rmed Forces?)		es, specify Cuban,				White, etc.	
fter de		3 Widowed 4 D	ivorced If Yes,	Give Year	X No	1	Yes 2X No	specify:			Specify: BL	ACK
ours a atura	g b	15. Decedent's Education (Sp	or Date ecify only high		npleted)		t's Usual Occupationst of working life.			16b.	Kind of Business	/Industry
6 172 h an "n	lete	Elementary/Secondary (0-12	.) Co	ollege (1-4 or	5+)			DO 1407 430	retired)			
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	8	19a. Informant's Name/Relation	<u>'</u>	•		19b. Mailing	Address (Street					e, Zip Code)
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e, h l and Health item	1	20a. Method of Disposition			20b. Pl	ace of Dispos ematory or oth	ition (Name of cerr	netery,	V. 20		ORE MD Location - City of	r Town, State
MOF Pages ent of mt: If		1 Burial 2 Cremati 4 Donation 5 Other		moval from St	ate	-	OUNT CR			, 200		ORE, MD.
Baltimore, permit. Pages 1 at Department of He Important: If ite	-	21/ Signature of Funeral Service		/	- 010	a 22. N	lame and Address	of Facility		TNIED		
		Kermann	27!	Acres	agg	114	LVIN B. 12 E. P	RESTO	N ST.	BAT	TO.MD.	21213
Physician		23a. Part I. Enter the disease, failure. List only one caus	or complication se on each line	ns that caused e.	I the death. [Oo not enter ti	ne mode of dying,	such as cardia	ac or respirator	y arrest, sh	nock, or heart	Approximate Interval Between Onset and
/Medical Examiner	1	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									Death	
	П	or condition resulting in death,	Due to	(or as a cons	equence of):							
	ē	Sequentially list conditions, if any, leading to immediate		(or as a cons	equence of):							
	Examiner	cause. Enter Underlying Caus (Disease or injury that initiated	Dive to	(or as a cons	oguenne of)							
ted /		events resulting in death) Las	d Due to	(Or as a cons	equence on).							
0, e be executed /sician and burial - transit	edical	UNPENDED	AME	ENDED								
760 cate b physic	/Me	IF FEMALE: 23b. Was decedent pregnant in		. If yes, outco	me of pregna			7		2	3d Date of delive	
Box 6876(ne death certificate the attending physele for use as the b	Physician/M	past 12 months?		Live birth Pregnant a	t time of dea		tal death 3 L	Ectopic pre	gnancy		Month	Day Year
30x death	ysic	1 Yes 2 No 9 U	Inknown 9	Unknown		3 01	ner (apechy)					
<u>-</u> + ≎⊃		Part II. Other significant con-	litions contri	ibuting to deat	h but not res	sulting in the t	ınderlying cause g	iven in Part I.		_		o the cause of death?
ires that signed to be deta	ed by											obably 4 Unknown
ords ** requi s been should	Completed									Nas an autopsy	prior to	autopsy findings available ocompletion of cause of
(ecc	mo									erformed es 2	? death?	
tal Reco	Be C	25. Was case referred to medi						of Death (Che	eck only one)			
Vita hysici this c	To E	examiner? 1 ✓ Yes 2 No	Hospita	al: 1 Inpati		ER/Outpatient					dence 6 Othe	er:
n of ling Pt After funeral		27. Manner of Death 1 Natural 5 Death		8a. Date of Inj (Month, Day, Nov 11, 2000		28b. Time of I 1825 hrs		ry at Work? ∕es 2 ✔ No	Subject		njury occurred	
ivision I or Attend after death. Director:	cati		vestigation						Of Locat	ion (Stroot	and Number or E	Rural Route Number, City
Division of Vital Records, tal or Attending Physician: The law require rs after death. "I Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	de	ould not be	(Specify) Lo			et, factory, office b	uliding, etc.			an Street , Baltin	
Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the		29a. Certifier					rred at the time, da	ate and place	1			
To the Ho within 24 t To the Fu	Medical	one) 2 ✓ Medical E	xaminer: On th	ne basis of exa	amination an	d/or investiga	tion, in my opinion	, death occurr	ed at the time,	date and p	place, and due to	the cause(s)
To To	Mec	29b. Signature and title of cert		manner stated			29c License	e number		290	d. Date signed (M	ionth, Day, Year)
		Jachor	100	el K	W		O.C.1	M.E.		No	ovember 12, 2	2006
		30. Name and address of pers	on who comple	eted cause of	death (Item :	23a)						
7		Tasha Greenberg M	D. Assis	tant Medic			Penn Street,	Baltimore,	MD 21201	_		
	tate	1.00.1	1 7 200	32. Registr	ar's Signatur	e de	Carte					
Regis	ual	NOV	1 3 400	4 4480	Holy Soft	13 July 18	Shear Alberta					

					State of M				of Woolth		-		-		
		-	For State		State of IV	aiylai			of Death		,	_		36	172
		- 13	Registrar 1. Decedent's Name (First, Mi	nidla last)		Cel	lincale	OI Deall		2. Date of De		006		of Death
PI	hysicia		_	Jule, cast	,						Month	12	200	r	
	Medic	_	Jean A. Todd 4a. Facility Name (If not institu	tion and	street and number			4h City T	own, or Location	n of Death	11		County of De		20a ^M
L.	xamin	er		_						ii Oi Dealli					
F-12			13123 Superion 5. Social Security Number	6. Se		ge (In yrs.	last birthday)	Rockv tf Under 1		er 24 Hrs.	8. Date of Bir	th	lont go	nery linthplace (Stat	e or Foreign
	neral ector		213-24-3932]м 2√Г F	7		Months	Days Hours	Min.	8. Date of Bir (Month, Da 04-22-	y, Year)		country)	
			Usuet Residence of Decedent											ar y adma	
rylan	=		10a. State 10b. Cou	•		10c. Cit	y, Town or Lo	cation							City Limits
e Ma	4	cto	MD Mon	tgom	ery	Roo	ckville	2				_		1 DY	es 2 No
를 를 된 경		Director	10e. Street and Number 13123 Superi	C				10f. Zip (10g. Citi	zen of What	Country?	
d 21215-0036 filed within 72 hours effer death with the Maryland Hygiene.	s marked direction nation; of remarks on occessions aumatic avant, the Modical Examiner must be notified at	<u>a</u>	13123 Superi	or 5				208				USA			
er de	ä	nue	11. Marital Status		12. Was Decedent Armed Forces	?	.S. 13.	Was Decede If Yes, specif	nt of Hispanic (y Cuban, Mexic	Origin? (Spe an, Puerto I	cify Yes or No Rican, etc.))-	 Race - Al Black, W 	nerican Indian. nite, etc.	
36 seffe	ם	YF	1 ☐ Never Married 2 ☐ N Widowed 4 ☐ Divorce		1 ☐ Yes 2 🔀	No		1 ☐ Yes 2	No Specif	fy:			Specify: W	ite	
	필	Completed by Funeral	15. Dece		Year or Dates:		16a Doce	dent's Usual	Occupation			16h V	nd of Busine	and advetor	
15 in 72	office	Set	(Specify only hig	hest grad	e completed)		(Give	kind of work DO NOT use	done during metired)	ost of workii	ng	100. KI	na or busine	ss/industry	
with iene.	8	E	Elementary/Secondary (0-12	2)	College (1-4or	5+)	Clerk		, , , , , , , , , , , , , , , , , , , ,			Foo	d Serv	rice	
Hyg	T.	Be C	17. Father's Name (First, Midd	lle, Last)					18. Mot	ther's Name	(First, Middle			ICE	
an id be ental	N O	To B	Unknown						IImi	less 02 mm					
shound M	T T	-	19a. Informant's Name/Relation	onship (T)	rpe, Print)		19b. Mailir	ng Address (Street and Num	known iber or Rura	/ Route Numb	er, City o	r Town, State	, Zip Code)	
E Se Se Se Se Se Se Se Se Se Se Se Se Se	rtra		S. Maribel Ru	iz/Fı	ciend		1005	Summer	r Sweet	I.n. Mt	- Airv	MD	21771		
S 1 a	oth		20a. Method of Disposition				Place of Dispo	sition /Name	of		ate			or Town, State	
Pages ment of	7 0		1 ☐ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	on 3 ⊡F (Specify)	Removal from State	Ch	esapea	ke Cre	ematory	11-15	-2006	Be1t	sville	• MD	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours elt Department of Health and Mental Hygiene.	infu .	-	21. Signature of Funeral Serv		00				Address of Fac						
m gai	any in			2	200	358	Ra	nn Fur	neral &	Croma	S action	11003	r Spri	ng, MD	110
	7.1		23a. Part1. Enter the disease shock, or heart failure. 1	or comp	ications that cause	d the deat	h. Do not ent	er the mode	of dying, such a	as cardiac o	r respiratory a	rrest,	3 GISL	Approxin Interval	nate
Phys	ician		Immediate Cause (Final	ust only o										Onset an	nd Death
	dical		disease or condition resulting in death)	-	a. Rectal Due to (or as									18 mor	iths
Exan	niner													Ī	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execute)	,	Due to (or as	a conseq	uence of):								
cuted	ransl	Examiner	trial mitiated events	1	c.										
760, e be executed	nysicien and he burial-transit		resulting in death) Last		Due to (or as	a conseq	uence of):								
376 ate be	ne bu	ca		•	d			·							_
		Physician/Med	IF FEMALE:												
SO SI	for use est	an/	23b. Was decedent pregnant	2	23c. If yes, outcome 1 Live birth			Ectopic pres	anancv			:	23d. Date of	,	
). E	ed fo	SCI	in the past 12 months?		4☐Pregnant a			Other (spec					Month	Day	Year
P.O. Box	be detached f	Phy	9 Unknown												
<u>v</u> §	000	þ	Part II. Other significant cond	nuons co	nthouting to death	out not res	uiting in the u	nderlying cau	ise given in Par	t I.				to the cause of	
Division of Vital Records, or Attanding Physician: The law requires I affar death.	should	Completed									15	Yes 21	□No 3□	Probably 4	Unknown
a e	2 2 5	ple									24a. Was		24b. Were	autopsy finding	gs available t cause of
H 4	pag	Con									perfo	rmed? 2 No	death	? es 2 No	
/ita	ector,	Be	25. Was case reterred to med examiner?	-						ce of Death	(Check only	one)			
of Vital Physician:	al dire	2	1 ☐ Yes 2 No		Hospital: 1 ☐ Inpat		ER/Outpatier				ne 5 Resi			pecify)	
E ga	uner	ü	27. Manner of Death 1 Natural 5 ☐ Per	iding	28a. Date of Inj (Month, Di	ury ay Year)	28b. Time of Injury		c. Injury at Work?		28d. Describe	how injur	y occurred		
VISION Attending ir death.	the f	Certification;	Z C / NOCIGOIN	stigation ild not be				М	1 Yes 2						
DIVISIC Hospital or Attano 24 hours after death	in by	H	4 Homicide det	ermined	28e. Place of In building, e	jury - At hi tc. <i>(Specif</i>	ome, tarm, str y)	eet, factory,	office	2	28f. Location (City or To			Rural Route N	um <i>ber</i> ,
pital urs a	Pell		an a seller defend	h.i Dh	1.00 = 30 km										
Hos	run tely f	lica	29a. Certifier 1 Certifier (Check only 2 Medic	rying Phy cal Exami	sician: To the besi	or examina	wledge, deatl ition and/or in	n occurred at vestigation, i	the time, date a n my opinion, de	and place, a eath occurre	and due to the ad at the time,	cause(s) date and	and manner place, and d	as stated. ue to the caus	e(s)
To the Hospital within 24 hours	Lo na Funeral brector, Alter rins certificete has completely filled in by the funeral director, paga 2.	Medicai	29b. Signature and little of cert		and manner s	ialeu.			License numbe					nth, Day, Year	
F 3 F	- 8		1 X/C	22	5-6)				4588				4-2006		′
\wedge			20 No.		amalated	death ""	- 00-1 7		7000	<u></u>		11-1	4-2000		
1			30. Name and address of pers					,	- 100 0	0050					
The state	Sta	10	Leon Hwang, M		1396 Picc 32. Regis	rar's Signa	or. Koc	A		0850					
	5ta legistr	_	NOV		2006	2000	D.	Const.	1						

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 3:10 AM M November Kimberly D. Valente /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Year) Aug 29, 19 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 V F 45 1961 Director Maryland 212-82-3907 Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at Baltimore Parkville 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3138 E. Joppa Road 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "I only or other traumatic event, the Med any Injury or other traumatic event, the Med one. Elementary/Secondary (0-12) College (1-4or 5+) 12 0 office manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Donald O'Hara Norma Lee Pohl 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Valente/spouse 3138 E. Joppa Road Parkville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ 21201 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each,line. 23a. Part1 Enter the disease, or conshock, of heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cars /Medical Due to (or as a consequence) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical ass IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Was an has N autopsy page performed2 certificate 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 2 ER/Outpatient 3 DOA 1 ☐ Inpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Affer or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident To the Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chales St. Bolts. Md ZCZOX 6701 GBM(32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar 5

			For State Registrar	State of M	laryland / De <i>C</i>	partment of ertificate o	Health and f Death	Mental Hy	rgiene2 () ()	6 36175
	Physici	an	1. Decedent's Name (First, Middle,					2. Date of De Month	Day Y	3. Time of Death
1000	/Medic	al	LORETTA 4a. Facility Name (If not institution,			4b. City, Town	, or Location of Dea	NO V	4c. County of	
100 A	Examili	er	Genesis Brigh				erville			imore
	Funeral Director				ge (In yrs. last birthda	y) If Under 1 Ye	ar If Under 24 Hrs	8. Date of Bi March		Birtholage (State or Foreign
100	pug 🛊		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryla f sho	lor		altimore		herville				1 ☐ Yes 2X No
	with the 3a or 28a	I Direct	10e. Street and Number 515 Brightwood	d Road	.1	10f. Zip Code	093		10g. Citizen of Who	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "naturel", or itema 23a or 28a-f show any njury or other traumatic event, if a Mudical Examitive most be notified at ange.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces d 1 Yes 2 If Yes, Give Year or Dates] No	3. Was Decedent of If Yes, specify C	of Hispanic Origin? (uban, Mexican, Pue No Specify:	Specify Yes or Norto Rican, etc.)		American Indian, White, etc. White
5-0	72 ho	eted	15. Decedent's		16a. De	cedent's Usual Occive kind of work do	cupation ne during most of wo ired)	orking	16b. Kind of Busin	ness/Industry
12	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4o		e. <i>DO NOT use ret</i> I memaker	ired)		Own h	ome
9	filed y Hygie other i	e Co	17. Father's Name (First, Middle, L	ast)			18. Mother's Na	ame (First, Middle	e, Maiden Sumame)	
an	lid be fental rked c	To Be	George	Rein	eker		Anna		Mille	r
Maryland	ind 2 shou alth and N 27 is mai		19a. Informant's Name/Relationsh Gregory Stone-(-	eet and Number or F Ice Dr.,		per, City or Town, St.	
Baltimore,	of He of He if item ir oth		20a. Method of Disposition 1 XBurial 2 Cremation	3 DRemoval from Stat		sposition (Name of trematory or other p		Date	20c. Location - Ci	•
Ē	ment tant:		4 ☐ Donation 5 ☐ Other (Sp	ecify)	Most Hol	y Redeem		/13/06	Baltimo	
Ba	Departition of the process		21. Signature of Euneral Service L	⊶seeW1111am	G. Dau					1 Home, Inc.
			23a. Part1. Enter the disease, or o	complications that cause	ed the death. Do not		ork Rd., tying, such as cardia			Approximate
	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a GAN		LEF.	T FOOE			Interval Between Onset and Death
,00	Medical Examiner 3 physicien end as the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PERIP Due to (or a	is a consequence of):	VASCU TO TH	RIVE) ISEA)E	days
P.O. Box 68760,	law requires that the death certificate be executed as been signed by the ettending physicien end 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death	3 □Ectopic pregna 5 □ Other (specify)			23d. Date of Month	,
	s that ned b e deta	by Pl	Part II. Other significant condition	s contributing to death	but not resulting in th	e underlying cause	given in Part I.	23e. Did	tobacco use contrib	ute to the cause of death?
rds	w require been sig should b							10	Yes 2□No 3	Probably 4 Unknown
Vital Records,	The ete h page	Completed						24a. Was auto perf 1 Yes	opsy prio	re autopsy findings available or to completion of cause of ath? Yes 2 \sum No
Vita	Physician: The this certificate hiral director, page	Be	25. Was case referred to medical examiner?	Hospital:			Othor	eath (Check only		
of	<u>ਦ</u> ਦੁ ਲ	. T	1 Yes 2 No	i 🗀 inpa		tient 3 DOA			how injury occurred	
on	Attending in death. ector: After by the funer	tlon	Natural 5 ☐ Pending 2 ☐ Accident investig		Day Year) Inju		njury at Vork? ☐ Yes 2 ☐ No	200. 2000.20	mon injury occurred	
Division of	i Dir	ertification:	3 Suicide 6 Could n 4 Homicide determi	and 288. Place of I	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office	се		(Street and Number own, State)	or Rural Route Number,
	Hospitel 24 hours a re Funerel I	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the be- examiner: On the basis and manner	of examination and/o	eath occurred at the rinvestigation, in m	time, date and place y opinion, death occ	ce, and due to the curred at the time	e cause(s) and mann , date and place, and	er as stated. d due to the cause(s)
	To the within 2 To the complei	Ž	29b. Signature and title of certifier	-5	^		ense number		29d. Date signed (
)	1		•	Spep	ite no	DO	05315	O	NOV 8	th 2006
	5		30. Name and address of person of SHAWN N	the completed cause of	death (Item 23a) (Ty	pe, Print)	VILACO	RO SIL	17810	6005 th Section 19 1404 04
	≝ ⇒ St	ate	31. Date filed (Month, Day, Year)		strar's Signature		40	,		2 9 0 13
1	Regist	rar	NOV 15		w. H	Tours ?				
DH	HMH 17 Rev 1/2	001			ORI	GINAL				

			1 - State of Maryl	land / Department Certificate		Mental Hygier	2006	36176
,	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number)	46. City, T	own, or Location of Death	November	Day Year Ac. County of Dea	3. Time of Death 7:15 A M
	Funeral Director		5. Social Security Number 350-14-767/ 1 M 2 F 7. Age (In.) Usuel Residence of Decedent	yrs, last birthday) If Under 1 Yrs. Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yea	718 Sox	thplace (State or Foreign buntry) LH (Alalina
	Maryland e-f ehow	ctor		:. City, Town or Location Baut	imore			10d. Inside City Limits
	eth with the 23a of 28 ust be no	Funeral Director	10e. Street and Number 42 Ben Kert Avl.		21223		Citizen of What Co	A
5-0036	iours efter de iral', or iteme L'Examiner m	by	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes, Give Year or Dates:	in U.S. 13. Was Decede If Yes, specif	ent of Hispánic Origin? (Sp fy Cuban, Mexican, Puento PNo Specify:	pecify Yes or No- Rican, etc.)	14. Race · Ame Black, Whit Specify:	
21215-(be filed within 72 hours effer deeth with the Maryland Hygiene. Hygiene, do other then "netural; or Iteme 23s or 28e-f ehow event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) OH College (1-4or 5+)	life. DO NOT use	done during most of work pretired) The state of the stat	ung	Howar Uni For	-d
	e d in b	To Be	17. Father's Name (First, Middle, Last) Faul Arthory		ma	e (First, Middle, Maid	avis	
	s 1 and 2 should of Heelth end Men Nem 27 le marke other treumatic		19a. Informant's Name/Relationship (Type, Print) Lo III weeks SR husba 20a. Method of Disposition	end 42 Benli		acto, md,		23
altimore,	Pege ent o nt: if ry or		4 Donation 5 Other (Specify)	Db. Place of Disposition (Name cometery, crematory or other day HILL	cem. ""	5/06 G	len Beu	nè, md.
Ba	Depertm Depertm importe eny inju		21. Signature of Foneral Service Licensee Lanch Lanch 23a. Part Ener the disease, or complications that caused the complex to the	1270 F	Address of Facility (Pass Bal	arch F/	Approximate
	hysician /Medical		shock or heart failure. List only one cause on each line.	Supply Sevents and the mode of		or respiratory arrest,		Interval Between Onset and Death
E	Examiner	er	Due to (or as a con Sequentially list conditions, if any, leading to immediate Due to (or as a con Due to (or as a con					
	rate be executed thysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a con	nsequence of):		***************************************		
09/89	tificate be ig physicia as the bur	ledical						
P.O. Box	The law requires that the death certificate be executed to has been signed by the ettending physician and bege 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of prediction in the past 12 months? 4 ☐ Pregnant at time 9 ☐ Unknown	Fetel death 3 ☐ Ectopic pred			23d. Date of de Month	livery Day Year
ords, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not		use given in Part I.	23e. Did tobacc	./	o the cause of death? robably 4 □Unknown
Division of Vital Records,	hysicien: The law r his certificate has be I director, pege 2 sh	Completed	0 /			24a. Was an autopsy performed 1 Yes 2	death?	utopsy findings available completion of cause of
!	Physicien this certif al directo	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital: 1 □ Inpatient	2 ☐ ER/Outpatient 3 ☐ DOA	Other	th (Check only one) ome 5 Residence	6 ☐Other (Spe	cify)
ouois	fler t nera		27. Manner of Death t ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Yea.	28b. Time of Injury M	c. Injury at Work? 1 Yes 2 No	28d. Describe how in	jury occurred	
<u>N</u>	5 # 5 E	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp	At home, farm, street, factory, oecify)	office	28f. Location (Street City or Town, Str	and Number or Ri ite)	ural Route Number,
	To the Hospital within 24 hours e To the Funerel (completely filled	Medical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my 2 ☐ Medical Examiner: On the basis of examand manner stated.	knowledge, death occurred at nination and/or investigation, in	t the time, date and place, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as and place, and due	s stated. s to the cause(s)
)	To the training of training of the training of trainin	×	29b. Signature and title discentiver	29c.	License number	29d. [Date signed (Mont	h, Dey, Year)
	V		30. Name and address of person who completed cause of death ((Item 23a) (Type, Print) 716 MMDEN	CHOICE	CN CAT	onsv/ll	106 E, KM 21228
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's S	ignature				

DHMH 17 Rev 1/2001

			1- State of Maryland / Department of State of Maryland / Department of Certificate of			ene 2006	36177
	Pĥysici		1. Decedent's Name (First, Middle, Last) MARRIS 1.201 MER		2. Date of Death Month	Day Year	3. Time of Death
	/Medio Examin			or Location of Death	7770 7	4c. County of Death	10.01
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		8. Date of Birth	9. Birth	place (State or Foreign
	Director		215-09-4072 1⊠M 2□F 86 Yrs. Months Days Usual Residence of Decedent	Hours Min.	(Month, Day,) June 11		cyland
	aryland show	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-f	Director	Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code		100	g. Citizen of What Cou	
	s 23a c		1000 Kent Avenue 2122			USA	
036	urs after de al', or Itams Examiner n	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ No	Hispanic Origin? (Spectan, Mexican, Puerto For Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whit	etc.
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic avant, the Medical Evantical must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	ng 16	6b. Kind of Business/In	
ק ט	e filed v il Hygie othar I vant, It	Be Co	12 Draftsman 17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	Engineeri	ıng
ylar	should by	ToE	Morris H. Walmer	Gertrude			
, Ma	of Health and I slitem 27 Is r		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stree Thomas Frantz Nephew 4767 Ilkley M				230
Jore	Pages 1 and of He int: If itam		Thomas Frantz Nephew 4767 11kley No. 20a. Method of Disposition 1□ Burial 2 ⊠Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) 1 □ Burial 2 ⊠ Crematory or other pla	De 11/15/		oc. Location - City or To atonsville	
altin	permit. Pages 'Department of the Important: If its any injury or of once.		21. Signature of Funeral Service Licensee	ess of Facility Ster	cling Ast	nton Schwal	Witzke
B	40 E # 9					, Inc. nsville, M	21228 Approximate
	Pnysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		Transfer and a second		Interval Between Onset and Death
	/Medical Examiner		resulting in death) The to (or as a consequence of):				
	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Cities of Affairy				
38760,	cate be executed physician and the burial-transit	ıl Examiner	that initiated events resulting in death) Last C				
Ψ	tificate t g physions the b	ledical	d				
.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify) ☐ Unknown 5 ☐ Other (specify) ☐ Unknown 5 ☐ Other (specify) ☐ Othe	;y		23d. Date of delive Month	ery Day Year
<u>а</u>	n requires that the de been signed by the a should be detached f	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause grant AAA	ven in Part I.		cco use contribute to the	
Division of Vital Records,	ysician: The law requiscontificate has been director, page 2 should	Completed	- PVD		24a. Was an autopsy performe	24b. Were auto prior to condeath?	psy findings available impletion of cause of
Vita	sician: certific lirector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	26. Place of Death		ce 6 □Other (Specif	
n of	는 두 등	on: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 1 ☑Natural 5 ☐ Pending 28c. Injury Wo	ury at 28	8d. Describe how		Y)
Divisio	To the Hospital or Attending Physicien: within 24 hours state death. To the Funeral Director: After this certific compietely filled in by the funeral director.	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 4 ☐ Homicide determined M 1 ☐ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Yes 2 □No	8f. Location (Stre City or Town,	et and Number or Rura State)	Il Route Number,
	a Hospita 124 hours a Funeral letely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the to the death occurred at the to the death occurred at the to the death occurred at the to the death occurred at the to the death occurred at the to the death occurred at the to the death occurred at the to the death occurred at the to the death occurred at the total	ime, date and place, ar opinion, death occurre	nd due to the cau d at the time, date	se(s) and manner as s e and place, and due to	tated. the cause(s)
)	М	Ň	29b. Signature and title of certifier Nu Araul MD 29c. Licen D 3	se number > 9/2 7	290	1. Date signed (Month,	Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print). A. A. H. M. E. D. & Z. M. Euclaw S. T. Salli Me.	re MD	212	0 1	
:	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 5 2006 32 Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Nov 8, 2006 Year Physician Month 7:45 a Ernest Lee Williams, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Joseph Richey Hospice, Inc. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar 29, 1938 Birthptace (State or Foreign County)
 Waryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 DKM 2 □ F 68 Yre 219-26-9769 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow 1 ☐ Yes 2 ☐ No **Baltimore** Maryland N/A Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21217 827 North Arlington Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ **X**Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1962 Baltimore, Maryland 21215-0036 "natural", or Black 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced 1964 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other treumatic event, the Maulic page. Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) Welder 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Laura Colbert Ernest L. Williams Sr. ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1412 North Bond Street Baltimore, Maryland 21214 Betty Williams Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Md. 11/16/06 Garrison Forest Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 Part1. Enter the disease, or complications that caused the deat shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician metastatic /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires thet the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical ate has been signed by the attending page 2 should be deteched for use es 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Tes 2□ No Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 VOther (Specify) 1050164 မ this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation death. neral Director: A filled in by the fa 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours 6 To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and titte of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 838 TSOMD Kichey Hospice 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Frnest Williams

1 - For State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	Physici	an	1. Decedent's Name (First, Middle, Lass			-11-		2. Date of Death Month	Day Year	3. Time of Death	
	/Medic				Natalie W				ov 10, 2006	9:35 р м	
iliya i	Examin	er	4a. Facility Name (If not institution, give	4b. City, Town,	or Location of Dea		4c. County of Death	mum dal			
				320 Onole Cou				evern	Anne A		
	within 72 hours after death with the Maryland jene. Than "naturel", or Iteme 23a or 28a-f show about the mailcal Exercitor from the notified at the mail of the m		217-72-5220	7. Ag	e (In yrs. last birthda 48 Yrs.	Months Days			Year) Cour	place (State or Foreign htry) laryland	
			Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			1	0d. Inside City Limits	
		Director	Maryland Anne A	rundel			Severn			1 Yes 2 No	
			10e. Street and Number 1820 Onole Court			10f. Zip Code	21144	10	og. Citizen of What Cour U.S.A		
36		by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Dyes 2 Mit If yes, Give Year or Dates:		3. Was Decedent of If Yes, specify Cut		Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Specify:		
9			15. Decedent's Edi	16a. De	cedent's Usual Occu	pation		16b. Kind of Business/In	dustry		
Maryland 21215-0036		To Be Completed	(Specify only highest grad	e completed) College (1-4or 5	(G.	ive kind of work done e. DO NOT use retire	during most of wa	orking	Global Pa		
	Hyg Hyg It,		17. Father's Name (First, Middle, Last)			,		me (First, Middle, M	faiden Sumame)		
an	12 should be h and Mental 7 is markad o freumatic eve		James Williams, Sr.				Grace M. Hill				
Mary			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1820 Oriole Court Severn, Maryland 21144								
re,	- T = -		20a. Method of Disposition		20b. Place of Dis	sposition (Name of trematory or other pla	acel	Date 2	20c. Location · City or To	wn, State	
ima	Pag nent ant: f		1 Burial 2 □ Cremation 3 □ I Donation 5 □ Other (Specify)	Removal from State	-	t. Rest Cemet		11/15/06	Hanover, M	aryland	
Baltimore,	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Licens	· Ca	Das	22. Name and Addr		eral Service P	Δ		
	90F#9) loug !	11.00		1300 E	utaw Place E	eral Service, P Baltimore, Md	21217	•	
	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each lin	ne.					Approximate Interval Between Onset and Death	
			Immediate Cause (Final disease or condition resulting in death)	. Wet	anot	10 15	reasi	con	rer	2 years	
	Examiner		•	Due to (or as	a consequence of):					J	
1	\$.\$t.	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):						
/	ocuted nd transil	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	o							
60,	certificate be executed ding physicien and ise as the burial-transit		resulting in death) Last	Due to (or as	a consequence of):			7			
68760,	physicate s the l	dica	•	1.							
Box	etter for u	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 DNo 9 □ Unknown		2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	cy		23d. Date of delive Month	ory Day Year	
P.O.	res that t igned by be detac	y Physi	Part II. Other significant conditions co	ntributing to death b	23e. Did tobacco use contribute to the cause of death?						
rds,	To the Hospitel or Attending Physicien: The law requires that the dwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely tilled in by the funeral director, page 2 should be detached	ed by							1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown		
of Vital Record		piete						24a. Was ar	24b. Were auto	psy findings available	
R		Completed						perform	autopsy prior to completion death? 1 ☐ Yes 2 ②No 1 ☐ Yes 2 ☐ No		
ita		BeC	25. Was case referred to medical	26. Place of Deal				ath (Check only one	1		
f V		20	examiner? 1 ☐ Yes 275No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
			27. Manner of Death 1 XNatural 5 Pending investigation 3 Suicide 6 Could not be determined				28d. Describe ho	28d. Describe how injury occurred			
Division		Certification:		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
_		lical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
		Me	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (Month,	Day, Year)	
			(markaz M.)			2	D39505 N			Jovenber 13,2006	
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Glen Burie, MD. 21061 Yudhish Markan 305 Hospital Dr. Glen Burie, MD. 21061								
8	Sta Registi	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Vear) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature NOV 1 5 2006									

06-08450 Tionna Wicks

Please Type or Print in Black Indelible Ink

IOIIIIa VVICKS	1- For State 1- For State Certificate of Death Reg. No. 2006 36	100							
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year								
	4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Jphns Hppkins Hpspital Baltimore NA								
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth(MM/DD/YYYY) 9 Birthplace (State of Security Number 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	or .							
Director	219-75-6294 1 M 2XF Yrs. 3 27 Hours Min. 07-11-2006 Foreign Country) Md								
, any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside Cit	1							
daryland 28a-f show 1.af once. ector	Md. NA Baltimore 1 X Yes 2 Toe Street and Number 10f. Zip Code 10g. Citizen of What Country?	No							
Di life	721 N. Duncan Street 21205 USA								
er death with or items 23.	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Blad 15. White, etc.	ck,							
s after de ral", or i iner mu by Fu	Specity: DICCK								
hours "natur Exam									
215-0036 be filed within 72 hours at nial Hygiene rked other than "natural ent, the Medical Examin Be Completed by	Infant NA								
21215-0036 Juld be filed within 7 Mental Hygiene marked other than ic event, the Medica FO BE COMPIE	Wicks Toni Richan								
D 21 should be and Men 'is mar atic eve	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
nore, MD 2 ages 1 and 2 shou nt of Health and N t: If item 27 is n other traumatic	Toni Bishop Mother 721 N. Duncan Street, Baltimore, Md. 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State								
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other ti injury or other traumatic event, the Med	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify. Mt. Carmel Cem. 11-14-06 Dundalk, Md.								
Balt permit. Departe Import injury	21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202								
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and								
xaminer	Immediate Cause (Final disease or condition resulting in death) a Sudden unexplained death in infancy Due to (or as a consequence of):	h .							
<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
ted Insit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
760, frate be executed physician and the burial - transit	X define resulting in Geath) Last								
'60, ate be execut physician and ne burial - tra	WUNPENDED #23a,27,28a-f, perME, G863, 1/8/07 TT #23c If yes, outcome of pregnancy 23d Date of delivery								
certifice	- 100h 111 de-e-de-et	ear							
b. Box 687 the death certifi the death certifi by the attending ched for use as I	1 Yes 2 No 9 Unknown 9 Unknown								
P. C	1 Yes 2 No 3 Probably 4 V Un								
Records, The law requires ficate has been sig page 2 should bb Completed	24a. Was an autopsy findings a prior to completion of ca								
of Vital Records Jing Physician: The law requir After this certificate has been funeral director, page 2 should on: To Be Complete	performed? 1 ✓ Yes 2 No 1 ✓ Yes 2] No							
Vital ysician ysician director	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other:								
n of ding Ph									
Division o To the Hospital or Attending within 24 hours after death To the Funeral Director: Aft completely filled in by the fune edical Certification:	2 Accident Investigation Fnd 11/7/2006 Fnd 1:35 am unknown 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City								
Diversity of filled by filled Certification	4 Homicide determined (Specify) found in residence or Town State) /21 N. Juncan Street								
To the Ho within 24 To the Fu completed	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. One) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated								
E » E »									
9	30. Name and address of person who completed cause of death (Item 23a)								
0	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
State Registra									

			For State	State of Maryla		artment of F rtificate of		d Mer			0000	0010
			Registrar 1. Decedent's Name (First, Middle, Last)			- Illicate of	Dealli	2	Date of Deat	eg. No.	2006	3. Time of Death
	Physicia /Medic		, , , , , ,	WALDEN				2.	Month Novemb	oer	8, 2006	
)	Examin		4a. Facility Name (If not institution, give s 1010 Montrose Aven			4b. City, Town, o Laurel	Location of De	eath			County of Dear	
-	Foreset	27	Social Security Number 6. Sex	7. Age (In vrs	s. last birthday)	If Under 1 Year	If Under 24 H	Hrs. 8.	Date of Birth		9 Bir	thplace (State or Foreign
	Funeral Director			M 2₽F 77	Yrs.	Months Days	Hours N	/lin.	(Month, Day, ec 25,	, Year)	Co	orgia
	p ,		Usual Residence of Decedent	100.0	ity, Town or Lo	position						10d Inside City Limite
	laryla shov ed at	J.	10a. State 10b. County			Cation						10d. Inside City Limits 1 ☐ Yes 2 ☐ No XX
	the N 28a-f notifie	Director	Maryland Prince G	eorge's La	aurel	10f. Zip Code			1	On Citi	izen of What Co	<u> </u>
	3a or		1010 Montrose Aven	ue		20707	7				S.A.	,
	ms 2	Funeral		12. Was Decedent Ever in	J.S. 13.	Was Decedent of H		? (Specify	Yes or No-		14. Race - Ame	
2	permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ② Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 □ Yes 2 □ X YX	Specify:	ueno nica	an, etc.)		Black, Whit	e, etc. hite
5	2 hou atura		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation			16b. Ki	ind of Business	/Industry
7	thin 7 e. an "n Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired	during most of d)	working				
4	led wi lygien ner th it, the		Grade 12		Sec	retary	40 84-45	N (F)			Manufa	cturing
2	be fil ntal H ed oth even	Be	17. Father's Name (First, Middle, Last)	_			18. Mother's I				,	
3 7	hould d Mei marke matic	ပ္	Henry Jackson Burk		19h Maili	ng Address (Street			e Mumf		-	Zin Code)
2	nd 2 s Ith an 27 is i		Douglas Connell	/ friend		Hobbs Ro			od, Ma			738
Ú	s 1 ar f Hea item (20a. Method of Disposition	20b.		osition (Name of matory or other place		Date			ocation - City or	
2	Page tent o nt: If		1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		emetery	1	1/13/	/2006	Bu	rtonsvi	lle, Maryla
5	permit. Departri Importa any inju		21. Signature of Funeral Service License			Name and Addre						
3	89 5 6		165 Scor	/ M007		313 Talbo					Marylan	d 20707
1	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a. <u>Advanced Te</u> a.	erminal				espiratory arr	est,		Approximate Interval Between Onset and Death
	Examiner			Due to (or as a conse Sacral Decu	•	Illcer						
۸.	اختر	ler	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse		01001						
	ficate be executed physician and stransit the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Failure to								
5	be exectan a	EX	resulting in death) Last	Due to (or as a conse	equence of):							
2	physi physi the l	dical										
. DOY	eath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ We 9 □ Unknown	3c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnanc □ Other <i>(specify)</i>	/				23d. Date of de Month	livery Day Year
	that hed by deta		Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.		23e. Did tol	bacco ı	use contribute to	the cause of death?
2	w requires that the de been signed by the should be detached	ed by						_	1 □ Y	es 2	XX No 3∏P	robabiy 4 □Unknown
כ ט	law re as bee 2 sho	Completed							24a. Was a		24b. Were a	utopsy findings available completion of cause of
	The ate ha	Com							perfori	med? 2 X N o	death?	
2	cran: sertific sctor,	Be	25. Was case referred to medical examiner?	foonital:		104	26. Place of	Death (C	heck only on	ne)		
5	Physi this c	2	1 ☐ Yes 2 X No	fospital: 1 ☐ Inpatient 2[28a. Date of Injury	BR/Outpatie		4 🗆 Nursir		5 XX eside		6 ☐Other (Spe	cify)
5	*Attending Physician: The laving death, rector: After this certificate has by the funeral director, page 2	ation	MXNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2∐No	200	. Describe no	ow injui	ry occurred	
2	al or Atter all after de I Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spec		reet, factory, office		28f.	Location (SI City or Town			ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Sertifying Phy (Check only one) 1 Sertifying Phy 2 Medical Exami	sician: To the best of my killiner. On the basis of examinand manner stated.	nowledge, deat	h occurred at the till vestigation, in my o	me, date and popinion, death of	place, and occurred	due to the cat the time, d	ause(s date and) and manner a d place, and du	s stated. e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	1		29c. Licens		-	2		ite signed (Moni	/
			1	CX m	7		3678	6		11	1-10-	- 6
	10		30. Name and address of person who co	ompleted cause of death (Ite		Print) 115 Roes	ler Por	ad (len D	ימיוו	ie MD	21060
_		ite	31. Date filed (Month, Day, Year)	32 Registrar's Sign		TTO KOES	TET KOS	au G	TGII BI	urll.	re, MD	21000

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Mary Dorothy Wright ,2006 Nov. 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Air 1 Year | If Under 24 Hrs. Hours | Min. 1301 Allenby Ct. Harford Bel 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F 218.34.1823 04.18.1919 MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Harford Bel Air Director 1 ☐ Yes 2 ☐ NO 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1301 Allenby Ct. 21014 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes. specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2√2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☐ No Specify: White Specify. þ 3 Nidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Anthony William Bauhaus Lorretta Mary Cassidy 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Wright/Son 1301 Allenby Ct. BelAir, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov.11,2006 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And FuneralBalto. 101443 Alternatives 8717 GreenPastures Dr. MD 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic Heart Discor Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 7

Physician /Medical Examiner

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

11-10-06

Don

MARY D. WRIGHT

I.OSAM

e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the furneral director, page 2 should be detached for use as the burnar-transit cate he

Division or Vital Records, P.O. Box 68760,

8		■ 0	<u> </u>	
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opicpregnancy er (specify)	23d. Date of delivery Month Day Year
eted by Pr	Part II. Other significant conditions	contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 70 3 Probably 4 Unknown
Complet				24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
ğ	25. Was case referred to medical		26. Place of De	ath Check onl one
0	examiner? 1 ☐ Yes _2☐ No	Hospital: 1	□ DOA Other: 4 □ Nursing I	Home 5 dence 6 ☐Other (Specify)
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
Sertific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
edical	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Example 1 Medical Example	nysiclan: To the best of my knowledge, death occ miner: On the basis of examination and/or investion and manner stated.	urred at the time, date and plac gation, in my opinion, death occ	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
Ž	29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

HO054439

* 710 Bel Air, MD 21014

November 10, 200i

State Registrar lincent A. Giminaro Do MIS North Avenue 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year).

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:01 /Medical Sallie Elizabeth Williams November 12 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Baltimore 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs 5. Social Security Numbe Date of Birth (Month, Day, Year) **Funeral** Months Hours Days Min. 1 □ M 2 🔀 F Country) Director 69 259-56-5277 ual Residence of Decede 04/30/1937 GA Usual F 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Silver Spring 10f. Zip Code 1 ☐ Yes 2 🗷 No Director MD Montgomery 10e. Street and Number 10g. Citizen of What Country? 13215 Conductor Way 1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No death v Funeral 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Private Practice Attorney traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Caleb Smart Sallie Sears 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once. Edward L. Williams/Son 11C W. Biddle St. Baltimore, MD 21201-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MC Cremation 3 ☐Removal from State Nov 14 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility Beltsville, Maryland 2006 Style & Kohunum Rapp Funeral & Cremation Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately a complete the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately a complete the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately a complete the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** puy rema em eNS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed: this certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence Other (Specify OU) 1 ☐ Yes 2 🕅 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: All completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Division or Vital Records,

State

29a. Certifier (Check only

29b. Signature and title of certifier

Registrar

6565 CHARLES 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

BUDON. MO

Vovember 13 2006

			1 - For State Registrar	State of Maryland / De	partment of Health and ertificate of Death	Mental Hygier	300E 3E 18F
			Decedent's Name (First, Middle, Last,			2. Date of Death	3. Time of Death
	Physici /Medic		BRENDA V.	Young		NOVEMBER	Day 9 1 2006 15:19 M
7	Examin	er	4a. Facility Name (If not institution, give	4 4	4b. City, Town, or Location of Dea		4c. County of Death
	Funeval	-	5. Social Security Number 6. Sec	HOSPITAL 7. Age (In yrs. last birthda	Baltimore If Under 1 Year If Under 24 Hrs		
	Funeral Director			M 201 55 Yrs.	Months Davs Hours Min	8. Date of Birth (Month, Day, Yes	251 Country) MD
	p .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d locido Cityllimito
	ahov	ō	. 1				10d. Inside City Limits 1 (⊠Yes 2 □ No
	the h	Director	MD NA 10e. Street and Number	BALTIMO	10f. Zip Code	10g.	Citizen of What Country?
	3a or		745 YALE AVEN	IIIF	21229		USA
	deati	Funerai	11. Marital Status		3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
36	or Ite	by Fu	1 □ Never Married 2 Married	1 ☐ Yes 2 ♥ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	10 7 110211, 010.7	Specify
21215-0036	d within 72 hours after death with the Maryland Jiene. r then "neturel", or Heme 23a or 28a-f show the Marsical Esaninar must be notified at	ed b	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	cedent's Usual Occupation	all 16h	BLACK Kind of Business/Industry
15	nin 72	piet	(Specify only highest grad Elementary/Secondary (0-12)	e completed) (G College (1-4or 5+)	ive kind of work done during most of wo b. DO NOT use retired)	orking NA	N/A
212	ted within lygiene.	Completed	12-14 GRADE	N A			
nd	d of H	Be	17. Father's Name (First, Middle, Last)	•	_	me (First, Middle, Maid	len Sumame)
ryla	should had Ment	^L	EDWARD DIGGS 19a. Informant's Name/Relationship (T)	one Orient	Ruth		To Carlo Circo
Maryland	VI 60 - 60		BAKEERAH MOS		alling Address (Street and Number or R	luto. MD	2122Q
	s 1 and 2 f Heelth item 27 other tr		20a. Method of Disposition	20b. Place of Dis	sposition (Name of rematory or other place)		Location - City or Town, State
Ë	Pages nent of I int: if ite iry or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State LOUDEN		1.06 BA	LTO. MO
Baltimore,	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Licens	960	22. Name and Address of Facility VAUGHN C. GREENE F		
	805 g a		2 augun ()		5151 BAUTO, NATL PI	CE, BALTO.	mo 21229
ı			shock, or heart failure. List only or	ications that caused the death. Do not ne cause on each line.	enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	SEPSIS			TWOWEEK
	Examiner		ſ	Due to (or as a consequence of):	ONIA		TOUR WEEK
		ner	Sequentially list conditions, lary, leading to immediate cause. Enter Underlying	Due to (or +s a consequence of):			
	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury	c			
8760,	be ex icien a burial	al E	100011119 117 0001117 2201	Due to (or as a consequence of):			
687	ficate physis the	edical		d			
Вох	The law requires that the death certific ste hes been signed by the attending p page 2 should be detached for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	205		23d. Date of delivery
	deatine atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No		3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
P.O	that the de ed by the a detached	Phy	9 ☐ Unknown Part II. Other significant conditions con		a mada biisa sama a masa ia Bad I	320 Did tobace	to use contribute to the cause of death?
	signe d be d	d by	A 7 -		e underlying cause given in Parti.	1 ☐ Yes	/
SOL	w requir been si should	Completed				24a. Was an	24b. Were autopsy findings available
Re	The lav	d Ho				autopsy performed	prior to completion of cause of
ital		0	25. Was case referred to medical		26. Place of De	1 ☐ Yes 2/☐ ath (Check only one)	No 1 Yes 2 No
of Vital Records,		To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpa	ient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
n o			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury	y Work?	28d. Describe how in	njury occurred
Division	Attending Physic death.	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm,	M 1 Yes 2 No	28f Location (Street	and Number or Rural Route Number.
Di∨	after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	Street, factory, office	City or Town, St	ate)
	To the Hospitei or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, do	eath occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated.
	within 24 To the Fu	Medical	one)	ner: On the basis of examination and/o and manner stated.			
	To With	Σ	29b. Signature and title of certifier	M • C	29c. License number	1	Date signed (Month, Day, Year)
	1.1		20 Alexandren	Toland as was at death (trans as a 7	C01100001	No	uthistn 9 2006
	!		EXENFIEL QU	4NOW 3350WI	UENSAVE#307	- BACTIME	USMSON 9th 2006
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	A. A. A.		

ORIGINAL

DHMH 17 Rev 1/2001

			For State	State of Mar		artment of H			ene 2. No. 2. 0 0 6	36185
			Registrar 1. Decedent's Name (First, Middle, L	.ast)		-		2. Date of Death		3. Time of Death
	Physici		DOROTHY MA	E SHEPPA	RD	You	NG	NOVEMBER	9 2006	7:08 PM
5	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	r Location of Death		4c. County of Deat	1
			JOHNS HOPKINS BAYN	YEW MEDICAL	CENTER	BALTI			NA	
	Funeral			Sex 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1 06–18–1	9. Birti	nplace (State or Foreign untry)
	Director		577–72–7917 Usual Residence of Decedent	5	4 rrs.			06-18-1	.952	N.C.
	land ow		10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
	Man	ţō	Md. NA		Balt	imore				1 XYes 2 ☐ No
	h the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	filed within 72 hours atter death with the Maryland Hygiene. the than Insturel; or llems 23a or 28a-f ehow with the Macical Establishment be notified at	ai	608 N. Avonda	le Road		212	222		USA	
	or dea	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	orl	by Fi	1 ☐ Never Married 21 Married 3 ☐ Widowed 4 ☐ Divorced	I □ Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2√√ No	Specify:		Specify: Bla	ack
8	hour	edt	15. Decedent's		16a, Deced	ient's Usual Occup	ation	10	6b. Kind of Business/	
5	on 72	Completed	(Specify only highest of Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	during most of world	king		,
7	giene.	E	12th grade	2Yrs.		ses Assis	stance		Provident	Hospital
g	be file ital Hy od othe event	Bec	17. Father's Name (First, Middle, La.	st)			18. Mother's Nam	e (First, Middle, M	aiden Sumame)	
yla	should be ind Mental marked o	ဥ	John		ppard		Doreth		Kerne	
Baltimore, Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours atter death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then 'naturel', or items 23a or 28a-1 show or other treumatic event, the Marical Examiner must be notified at	l	19a. Informant's Name/Relationship	(Type, Print) Husband					City or Town, State, 2	
e,	permit. Peges 1 and 2 Department of Health a Important: If Item 27 is arry injury or other tre		David M. Young 20a. Method of Disposition	IIUSDAIIG	20b. Place of Dispo		ате коаа,	Baltimor	Ce, Ma. 2. Oc. Location - City or	L222
Jor	Peges nent of thint: If it		1√D Burial 2 ☐ Cremation 3	Removal from State	cemetery, crer	matory or other place mel Cemet			Dundalk, 1	
틒	artme ortani injury		4 Donation 5 ☐ Other (Special Services) Lice			. Name and Addres		March F.H		iu.
B	permit. Departr Importu		Dosek R	Waltersh				., Baltim		21202
			23a. Part. Enter the disease, or co	mplications that caused the	e death. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
ŧ.	Physician	0	Immediale Cause (Final disea e r condition result in death)	•	7.6	Rosin	In In	ucil		Onset and Death
1	/Medical		resulting in death)	Due to (or as a	consequence of):	4//	11	ur y		1 WEEK
	Examiner		Sequentially list conditions,	b	consequence of):	1 schem	ic Caro	Lionypo	thy	20 years
	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	опѕециенсе оп.			- 1		L
	and and li-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):					
8760,	icate be executed physicien and s the burial-transit	dical E								
687	ificate p phy as the	edic		d.					1	
Вох	eath certific attending p	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		Ectopic pregnancy			23d. Date of deli	very
	the death certifi y the attending iched tor use as	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tin		Other (specify)			Month	Day Year
P.O.	that the de ed by the a detached t	Ph	9 Unknown					00. 014.1		
	Se Ge	à	Part II. Other significant conditions	contributing to death but	not resulting in the ui	nderlying cause givi	en in Part I.	23e. Did toba	cco use contribute to	bably 4 Unknown
oro	w requir been si should	etec								
Rec	has ge 2	Completed						24a. Was an autopsy performe	prior to c	topsy findings available ompletion of cause of
æ			25. Was case referred to medical	-			00 Place of Date	1 Yes 2	SNo 1 ☐ Yes	2□ No
5	Physician: r this certific ral director,	To Be	examiner?	Hospital: 1 patient	2 ER/Outpatien	t 3 DOA Oth	or	th <i>(Check only</i> on <i>e,</i>	ce 6 □Other (Spec	rfu)
0	g Phy erthi		27. Manner of Death	28a. Date of Injury (Month, Day Y			y at	28d. Describe how		"")
<u>ö</u>	Attending r deeth. ector: Attel by the fune	atio	1 Accident 5 ☐ Pending investigat	ion	out, injury	1	Yes 2 □No			
Division of Vital Records,	or Att	Certification:	3 Suicide 6 Could not 4 Homicide determine		- At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	Hospital or 24 hours afte Funeral Dire tely tilled in t		29a. Certifier 1/X Certifying	Physician: To the best of	my knowledge, death	a accurred at the time	no, date and place	and due to the cau	uso(s) and manner as	atatad
	To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: Atter this certific completely illed in by the funeral director,	Medical		aminer: On the basis of ea and manner state	xamination and/or in	estigation, in my o	pinion, death occur	red at the time, dat	e and place, and due	to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely tilled	M	29b. Signature and title of certifier			29c. Licens			d. Date signed (Monti	
	1		1/2/	Medical	Doctor	RE	5-000	N	OVEMBER 9	, 2006
/) \		30. Name and address of person wh	o completed cause of dea	th (Item 23a) (Type,	Print)			OVEMBER 9 ANO 212	24
<i>م</i> لا	Sta	te	31. Date filed (Month, Day, Year)	940 EASTER 32. Resistrar's	Signature	E ISA	UIMURE	MARYL	4WO 212	.61
	Registr		NOV 1 5	2006 Jane	s Signature	hode				

			Registrar	State of Ma	ryland /	Depa Cer	rtmen tificate	t of H e of L	lealth a	and M	ental Hy	/gien Reg. N		5	36186
	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of D		ay Yea	r .	3. Time of Death
	/Medio		Edward Saulius 4a. Facility Name (If not institution, give s				4b. City,	Town, or	Location of	of Death	VC-VI	4	c. County of De		12731"
7				1705P11				B		HOK					
106 12:45M	Funeral Director		5. Social Security Number 6. Sex 1214-44-7846	7. Age M 2□F	(In yrs. last i	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth ay, Year	9. E	Country	e (State or Foreign
2			Usual Residence of Decedent								05/2	9/1	944 Li		
90	Aarylar Febor	ō	10a. State 10b. County		10c. City, To									10d.	Inside City Limits 1 ☐ Yes 2 X No
TS.	deeth with the Maryland me 23a or 28a-f ehow friust be nullied at	Director	Maryland Howard 10e. Street and Number		Wood	stoc	10f. Zip	Code				10g. C	itizen of What	Country	
	th witi	alD	10710 Croydon Co	urt			211	63				Un:	ited S	tat	es
M	er dee itame	Funeral		2. Was Decedent E Armed Forces?		13. V	Vas Deced Yes, spec	lent of Hi offy Cuba	spanic Ori	gin? (Spe , Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - Ar Black, Wi		
N.A. 036	72 hours after natural', or its dical Exemine	Ď	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 No If Yes, Give Year or Dates:	0	1	☐ Yes 2	No	Specify:				Specify:	hit	•
21215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		16	Sa. Deced	ent's Usua kind of wor	I Occupa	ation during mos	t of workin	a	16b.	Kind of Busines		
7 12	within ene. then	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+								a L			
	il Hygi other	Be Co	17. Father's Name (First, Middle, Last)	<u> </u>		eput	y Cr	ilei	of 18. Mothe		(First, Middle		ate Go n Sumame)	ver	nment
ylar	should by nd Menta marked umatic ev	ToB	Henry Armanas						Ele	na T	reide	eris	5		
Maryland	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Typ										or Town, State		,
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itame 23a or 28a-1 ehov array follows or other traumatic event, the Mudical Examinar round be published at 2008.		Donna Armanas – 20a. Method of Disposition		20b. Place ceme	0710 of Dispos	Cro	oydo	n Co	urt	Wood;	20c. l	ck Ma ocation - City	ryl or Town	and 21163 , State
S E	Page nent o ant: If ary or		1 ☐ Burial 2 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Bayvi				1	11/19	1/2006	Pal:	timore,	Mar	bre luc
Lyw Baltimore,	ermit. Sepertr Sports ny inju		21. Signature of Funeral Service License	2/1	1229 01	Da.	Name and	d Addres We	s of Facilit	Funer	al Hon	nes i	P.A.	1/2/1	Arang
	20 ≥ € Ø		23a Part I Enter the disease a Complic	WWY	the death D		11 Ec	mond	lson 7	Avenu	e Balt	imo	re, Mar		nd 21229
	Physician		23a. Part1. Enter the disease complice shock, or heart failure. St only on Immediate Cause (Final	cause on each line	9.	1/	Malia	e or dying	, such as	4 8				In	terval-Between nser and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence	e of):	Nalig	nan	T IV	1610	non	ra		-	1 yr
	Examiner	L	Sequentially list conditions, b.												
$\sqrt{}$	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequenc	e of):									
, o		Еха	that initiated events c. resulting in death) Last	Due to (or as a	consequenc	ce of):								+	
8760	ate the	dical	€ d											-	
9	Attending Physicien: The law requires that the death certific r death. actor: After this certificete has been signed by the attending pl purple transfer to the funeral director, page 2 should be detached for use as the transfer to the second process.	/Mec	IF FEMALE:	ic. If yes, outcome o	f oregnancy									1	
. Box	death e atter d for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 2 4☐Pregnant at t	Fetal dea		Ectopic pre Other (spe						23d. Date of d Month	Da	y Year
P.0	ires that the death signed by the atter I be detached for u	Phys	9 Unknown	9□ Unknown											
Division of Vital Records, P.O.	ires tha signed d be de	ρ	Part II. Other significant conditions conf	ributing to death but	t not resulting	in the un	derlying ca	ause give	n in Part I.				use contribute		ause of death?
COL	w requir been si should	Completed									24a. Was				
a e	The lay	ошо									auto	psy ormed?	prior to	o compl	findings available etion of cause of
/ital	nding Physician: The la ith: ; After this certificete has e funeral director, page 2	Bec	25. Was case referred to medical examiner?						26. Place	of Death	1 Yes	28 N оле)	o 1 □ Ye	95 ZL] No
of \	Physic this c	은	1 Yes 2 No	ospital:		Outpatient			4 □ Nui				6 □Other (Sp	ecify)	
on	th. ; After s fune	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury	м 2	Bc. Injury Work 1 □ Y	at ? ∕es 2.⊟h		Bd. Describe	now inju	iry occurred		
Visi	r Attendi er death ractor; A by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	y - At home,	farm, stre	et, factory,	, office		2	8f. Location (Street a	nd Number or	Rural R	oute Number,
Õ	urs afte rrai Dira			1											/
	To the Hospital or Attentwithin 24 hours after deating the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) To Certifying Phys 2 Medical Examin	cian: To the best of er: On the basis of a and manner state	examination a	lge, death and/or inv	occurred a estigation,	at the tim in my op	e, date and inion, deat	d place, ai th occurre	nd due to the d at the time.	cause(s date an	s) and manner and did place, and di	as state ue to the	d. e cause(s)
	To the within To the Compl	Me	29b. Signature and title of certifier				29c.	License				29d. Da	ate signed (Mo	nth, Day	v, Year)
	~		Lengt for	mly "	ND			D	185	87		N	bv 15	2	006
	8		30. Name and address of person who con	noleted dause of de	ath (Item 23a		100 A	1.	0_	R	2/4/10	711 10	bu is	-	1270
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	s Signature		ov 1	762		120	z (I VV	core	- 1014		1221
	Registr	ar	NOV 1 6 2006	TENER L	and the second										

Certificate of Death

4b. City, Town, or Location of Death

Reg. No.

Day

Year

2006

4c. County of Death

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

20785

1 X Yes 2 □ No

945 A M

2. Date of Death

Menth

MTUGBOKOH

To the Hospital or Attending Physician: within 24 hours efter death To the Funerel Director: , completely filled in by the f 1 - For State Registrar

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

TILEMON

4a. Facility Name (If not institution, give street and number)

Approximate Interval Between Inset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Denknown 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMORE NO ZIZUZ ST. PAU PLACE 25 JOSEPH 301 31. Date filed (Month, Day, Year) 32. Registrar's Signature **ORIGINAL**

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygien 2006

36188

Physician /Medical Examiner
Funeral

			1 - State Registrar	Otate of Mic		ertificate				eg. No.	30100					
			Decedent's Name (First, Middle, La	st)					2. Date of Deat		3. Time of Death					
	Physici /Medio		Lillian C. Au	stin					Novembe	er 9 2008	13:40 M					
À	Examir		4a. Facility Name (If not institution, give				n, or Location			4c. County of De						
			Shady Grove Adve				er Spr	_		Montgo	-					
	Funeral		5. Social Security Number 6. S 179–24–7186	Sex 7. Ag I□M 2⊠F	ə (İn yrs. last birthda 70 Yrs.		ys Hours	Min.	Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)					
	Director		Usual Residence of Decedent		78 Yrs.				lov. 4,	1920 Per	nsylvania					
	land ow		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits					
	Many Feb	to	Maryland Montgom	ery	Ro	ckville					1 ☐ Yes 2 🔀 No					
	r 28s	lrec	10e. Street and Number			10f. Zip Cod	ie		1	0g. Citizen of What	Country?					
	h wit	ai D	14431 Traville	Gardens Ci	rcle #409	20	850			U.S.A.						
	ee E	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	Was Decedent	of Hispanic O	origin? (Speci	ify Yes or No-	14. Race - An Black, Wi	nerican Indian,					
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hyglene. Important: if Item 27 le marked other then "natural", or Itame 23a or 28a-f ehow important: if Item 27 le marked other then "natural", or Itame 23a or 28a-f ehow apply injury or other treumatic event, the Modical Examinar must be notified at ODGE.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀			, oto.)		Black					
5-0	72 hc	Completed	15. Decedent's E (Specify only highest gra		16a. Dec	edent's Usual Oc	cupation	ost of working	,	16b. Kind of Busines	ss/Industry					
2	within ene. then	npi	Elementary/Secondary (0-12)	College (1-4or 5	+)	e kind of work do DO NOT use re		or or working								
	Hygier Hygier other th			4+	Reg	istered				Health Ca	are					
and	be fi	Be	17. Father's Name (First, Middle, Last							Maiden Sumame)						
Ĕ	should nd Men marka umatic	ပ	Louis Thomas Cle		105 145	U- Add /CA				Lambert City or Town, State	T- 0-1-1					
Maryland	elth an 27 le r			aughter)						arlboro, N						
J.	of He Item		20a. Method of Disposition		20b. Place of Dis	position (Name o	f place)	Dat	te	20c. Location - City	or Town, State					
Ē	Page nent ant: H		1 Burial 2 Cremation 3 5 4 Donation 5 Other (Special		Long Isl Cemetery	and Nati	ional	11–16-	-2006	Pinelawn,	New York					
Baltimore,	permit. Departr Imports eny inju		21. Signature of Funetal Service Lice	1500	V.	22. Name and Additzke Fi	dress of Faci ineral			mbia, MD						
			23a. Part1. Enter the disease, or com	plications that caused	the death. Do not e						Approximate					
	Physician		Immediate Cause (Final disease or condition	shock, or heart failure. List only one cause on each line. Interval Betwee Onset and Deat Onset and Deat												
	/Medical Examiner		resulting in death)	Due to (or as a consequence of): Acuto Penal Failure												
	Examine	3-	Sequentially list conditions, fany, leading to immediate b. Acute Renal Failure Due to (or as a consequence of):													
$\sqrt{}$	bed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Lympho							1 Year					
	security end	xar	that initiated events resulting in death) Last	C	a consequence of):			<u> </u>			1 1002					
68760,	tificate be executed og physician end es the burial-transit	calE		d. Pneumo	nia						1 Month					
68	uffical og ph es th	Medical														
Box	th cer lendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		□Ectopic pregna	ancv			23d. Date of d						
P.O. E	The law requires thet the death certificate be executed to be second to be been signed by the attending physician end bage 2 should be detached for use as the burial-transit	Physician/	in the past 12 months? 1 □ Yes 2 ᢒ No 9 □ Unknown	4□Pregnant at 9□Unknown		Other (specify				Month	Day Year					
G,	signed I	by P	Part II. Other significant conditions				•		23e. Did tob	pacco use contribute	to the cause of death?					
rg	w require been sig should t	pe	Lupus, Chronic	Renal Fail	ure, Pulm	ony Hype	rtensı	on,	1 □ Ye	s 2√2 No 3□	Probably 4 Unknown					
Records,	he law re hes be ge 2 sho	Completed	Essential Hyper	tension					24a. Was ar	n 24b. Were	autopsy findings available completion of cause of					
æ	The ate h	mo;							perform	ned? death'	?					
/ita	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Plac	ce of Death (Check only on							
of Vital	Physicien: this certificaral director, i	2	1 ☐ Yes 2½ No		nt 2 ER/Outpat			Nursing Home	5 Reside	nce 6 Other (Sp	pecify)					
ū	ding P. After 1 funera	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	y 28b. Time Year) Injury		njury at Work?		d. Describe ho	w injury occurred						
sic	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				1 Yes 2		I I continu (C)		0 -10					
Division	or Al efter Direct In by	Certification;	4 Homicide determined	building, etc	ury - At home, larm, c. (Specify)	street, factory, off	ice	28	City or Town		Rural Route Number,					
_	spital ours rerai filled		29a. Certifier 1 Certifying Pl	ysicien: To the best	of my knowledge de	ath occurred at th	e time date a	and place an	d due to the co	suse(s) and manner	as stated					
	To the Hospital or Attending Physicien: The within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 Medical Example)	niner: On the basis of and manner sta	examination and/or	investigation, in r	ny opinion, de	eath occurred	at the time, da	ate and place, and di	ue to the cause(s)					
	To the To the Comp	Me	29b. Signature and title of certifier		_	29c. Lic	ense number	r	25	9d. Date signed (Mo	nth, Day, Year)					
			WIN	1	mT		D05365	4	1	November 1	0,2006					
-	10		30. Name and addless of person who													
	1			01 Medical		rive Ro	ckvill	e, Mar	yland 2	20850						
	Sta Registr		31. Date filed (Month, Day, Year)	32. R distra	ar's Signature	desile.										

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

State Registrar (Check only one)

29b. Signature and title of certifier

NOV 1 6 2006

DHMH 17 Rev 1/2001

Kendall Moseley, The Johns Hopkins Hospital, 600 NorthWolfe Street, Baltimore Maryland 21287
31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated.

Kendall Moseley, Medical Doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

November 13, 2006

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene William Henderson Bentley 1- For State Certificate of Death Registrar Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Day November 14, 2006 1755 hrs Medical Examiner Bentley William Henderson 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** 2100 Mighty Acres Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6 Sex **Funeral** oreign Months Davs Hours 212-48-0542 Director Country) Kentucky 1 X M 2 F lovember 17, 61 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 1 Yes 2 X No 28a-f show Maryland Baltimore Dundalk death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21222 USA 2907 Dunbrin Road 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2X No Yes White after Yes 2 X No specify 3 Widowed Divorced If Yes, Give Year Specify ş 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ed ould be filed within 72 he de Mental Hygiene s marked other than "nice event, the Medical Exice event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) Complet MD 21215-0036 Laborer Factory 6 years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Preston Bentlev Mary Enyart Be permit. Pages 1 and 2 should be Department of Health and Ment. Important: If item 27 is mark injury or other traumatic even 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Barnes sister 705 Shore Road, Severna Park, Maryland 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town, State 20a. Method of Disposition November Baltimore, Oak Lawn Cemetery 1 X Burial 2 Cremation 3 Removal from State Dundalk, Maryland 17,2006 Other Specify Donation 5 Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. gnature of Funeral Service Licenses se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Atherosclerotic crdiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last pur Physician/Medical X UNPENDED AMENDED sician #23a,27,perME, g862, 12/11/06 TT Records, P.O. Box 68760, ending phys use as the bi 23d. Date of delivery Year 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown , the ; 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ð 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? page ✓ Yes 2 1 🗸 Yes certificate 25. Was case referred to medical 26 Place of Death (Check only one) Division of Vital Be Other₄ examiner? ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene Inpatient 2 this 1 V Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death or Attending 1 X Natural Yes 2 No Director: d in by the f 5 Pending 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) the Hospital Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) November 15, 2006 O.C.M.E. ame and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

ORIGINAL

Assistant Medical Examiner

2006

OCME 2006

State

Laron Locke MD.

31. Date filed (Mo

			1- For Amend #23A H	State of Marylan	19/Peré	ntment of h	lealth and Death	Mental Hyg	iene 0 0 6	36191
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
	/Medic		Catharine	2	RAG	<u>d</u>		Novemi	ser le , 20	06 00 12AM
	Examir	er	4a. Facility Name (If not institution, give s	street and number)	Marki	4b. City, Town, o	Location of Dea	more	4c. County of De	eath
	Funeral		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth	(Year) 9. E	irthplace (State or Foreign
	Director		220-18-3694	M 2⊠F 85	Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day, 1-17-	1921	VA VA
	and iand		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Many m-d-eh	tor	MD BALTIMO	RE	TURNER	STATION				1 XYes 2 No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code		1:	0g. Citizen of What	Country?
	e 23a	eral	304 CHESTNUT STRE		6 40.1	2122			USA	
' O	fter de	Fune	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No	.5.	was Decedent of H f Yes, specify Cuba	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Black, W	nerican Indian, nite, etc.
903	72 hours efter death with the Maryland netural; or Iteme 23a or 28a-f ehow disal Ezaminetroual be codified at	ρ	3XXVidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🏋 No	Specify:		Specify:	BLACK
15-("netu	iete	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wr	orking	16b. Kind of Busines	ss/Industry
21215-0036	within liene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		AL WORKE	,	ill services and the services are services and the services are services and the services are services and the services are services are services and the services are service	US POSTAL	SERVICE
	be filed within 72 hours efter death with the Marylan ital Hygiene. Id other then "netural", or liteme 23a or 28a-1 ehow event, the Mardical Examination in the collision at	BeC	17. Father's Name (First, Middle, Last)		'		18. Mother's Na	me (First, Middle, M		
yla		To	NATHANIEL VENABLE		1.			INE BARTE		
Maryland	C/ G = 0		19a. Informant's Name/Relationship (Ty						City or Town, State	
	s 1 and if Heelth Item 27 other ti		MYTRICE BYRD/DAUGH 20a. Method of Disposition	20b. F	Place of Dispo	CHESTNUT		_	20c. Location - City	AND 21222 or Town, State
E O			1 XX Purial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	natory or other place MEMORIAL	i i	1-11-06	BALTIMOR	E, MARYLAND
Baltimore,	permit. Page Dapartment of Importent: If any Injury or once.		21. Signature of Funeral Service License	* 7 . –	22	. Name and Addre	ss of Facility J	AMES A. M		ONS F.H., INC.
11.1	70 E # 9		James	1. Mjor		701-31 L			MORE, MD	
	D		23a. Part // Enter the disease, or complishow, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	n. Do not ent					Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consec	uence of):	Te:	rminal	Aspiratio	n	
H	Examiner		Sequentially list conditions	Gas	tric	Can	cer			
المذ	ted nslt	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
7	ate be executed hysicien and the burial-transit	Exar	that initiated events cresulting in death) Last	Due to (or as a conseq	uence of):					
ന	thysicie	licai		J						
9	leath certifica attanding ph I for use as ti	/Med	IF FEMALE:	3c. If yes, outcome of pregna	anov.					
Вох	death certific e attanding pl od for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 2 No	1 Live birth 2 Feta 4 Pregnant at time of o	ıl death 3 □	Ectopic pregnancy Other (specify)	,		23d. Date of d Month	elivery Day Year
P.O.		hysi	9 Unknown	9□ Unknown						
	9 P P	þ	Part II. Other significent conditions con	ntributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.			to the cause of death?
Records,	v requir been s should	eted								Probably 4 Unknown
Rec	The lay	Completed						24a. Was ar autops perform	y prior to	
	iclan: T certifical rector, p	BeC	25. Was case referred to medical				26. Place of De	1 Yes 2 ath Check only one		es 2 No
> t <	Physiclan: this certific ral director,	To E	1 1 185 22 110	- /	ER/Outpatien	t 3□ DOA Oth	or	IATILL TOOL	nce 6 □Other (Sp	pecify)
	fai	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 ⊡No	28d. Describe ho	w injury occurred	
Division	Attending r death. ector: Aftal by the fune	Ifica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, str		763 2 1140	28f. Location (Str	reet and Number or	Rural Route Number,
ā	rs afta	Certification;	4 Hornicide	building, etc. (Specif				City or Town		
	To the Hospital or Attendi within 24 hours aftar death. To the Funeral Director: A completely filled in by the fu	Medicai	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my knowner: On the basis of examina and manner stated.	owledge, death	occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
	ro the within ?	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	29	d. Date signed (Mo	nth, Day, Year)
	. , , ,		Dana	Dol Price	M	Re	S-00	1 1	lovembor	(0, 2006
	10		30. Name and address of ourson who co	mpleted cause of death (Item				15.3	() · C(· · · · · ·) * w	2122
	Sta	te.	31. Date filed (Month, Day, Year)	1070 HY41	iture -		d Bal	timore,	mo	46616
	Registr		NOV 1 6 2006	Marine B.	Bose	وينا				

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland /	Department of Certificate of		Mental Hygier Reg. I	71116	36192
			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		GEORGE WILLIA	M BENEDICT, M.D	.,Ph.D.		November	13, 2006	12:45P™
	Examir		4a. Facility Name (If not institution, give si	reet and number)	4b. City, Tow	n, or Location of Death		4c. County of Death	
			JOSEPH RICHEY HOS			imore City		N/A	
	Funeral		5. Social Security Number 6. Sex	M 2□F 7. Age (In yrs. last b		ear If Under 24 Hrs. lys Hours Min.	8. Date of Birth (Month, Day, Yes		lace (State or Foreign htry)
	Director		290-32-5992	69	113.		Dec 30, 1	1936 Ohi	.0
	wo w		10a. State 10b. County	10c. City, To	wn or Location			1	0d. Inside City Limits
	Mary feet	ţ	Maryland N/A		Baltimore	Citv			1 ☐ Yes 2 ☐ No
	r 28s	Director	10e. Street and Number		10f. Zip Cod		10g.	Citizen of What Cour	ntry?
	h witi	0	150 W. Lanvale St	reet		21217		USA	
	eep E	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,	
5-0036	72 hours after deeth with the Marylend Insturel', or itsme 23a or 28a-f show dical Examiner must be notified at	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give 22 Year or Dates:	1 □ Yes 2 📉		, . noan, o.c.,		Thite
2-0	n 72 ho	Completed	15. Decedent's Educ (Specify only highest grade		a. Decedent's Usual O	ecupation one during most of work	kina 16b	Kind of Business/In	dustry
2121	⊆ 2	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use re	tired)			
	filed withi Hygiene. Ither ther int, the k	S		5+	Assistant			Medical	
Pu	e d al b	Be	17. Father's Name (First, Middle, Last)	1.			e (First, Middle, Maid	len Sumame)	
718	nould be a Mental narked o	ု	George Livius Ben				le Berry	7 0 7	0-4-)
Maryland	id 2 sho lth and 27 is mu	3	Mrs. Mary I. Bened			reet and Number or Ru vale Street			
	Heal Heal Ther	- 4	20a. Method of Disposition	20b. Place	of Disposition (Name of	f !		Location - City or To	
5	Ø 0 == ==		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	ery, crematory or other	matory 11/	15/2006 Bo	1timoro 1	Martil and
Baltimore,		ŀή	21. Signature of Funeral Service License						
B	permit. Depertr Imports eny inju		Martin D. Paws	ペフィフ ^ヘ On	MITCHEL	dress of Facility L-WIEDEFELI	FUNERAL I	HOME, INC.	1010
			Martin D. Laws 23a. Part. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do	not enter the mode of	dying, such as cardiac	or respiratory arrest,	Marytand	proximate nterval Between
	Pnysician		Immediate Cause (Final disease or condition	(IV/IV/I)	na oft	vistate	mith	MAG	Onset and Death
1	/Medical		resulting in death)	Due to (or an a consequence	e of):	aloge	41/11	mes ,	
	Examiner		Sequentially list conditions b.		/				,
J	p #	Iner	if any, leading to immediate	Due to (or as a consequence	e of):			1	
Ą	cate be executed physicien and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	2 061:				
8760,	cien cuial burial	E		Due to (or as a consequence	5 017.				
87		dlcal	d.						
×	eath certifi attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23	sc. If yes, outcome of pregnancy				23d. Date of delive	arv
Вох	atter d for u	clar	in the past 12 months?	1 Live birth 2 Fetal deal 4 Pregnant at time of death	th 3 □Ectopic pregn 5 □ Other (specif			Month	Day Year
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٥,	es that igned to be det	by P	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause	given in Part I.	23e. Did tobaco	co use contribute to the	ne cause of death?
ğ	w require been sig should b		HINATOS	34/13			1 ☐ Yes	2/□ NO 3 □ Prot	ably 4 Unknown
ပ္သ	aw requisites been 2 should	plet					24a. Was an autopsy	200. Were auto	psy findings available mpletion of cause of
of Vital Records,		Completed					performed	death?	
Îta	i ii	Be	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)		11
Ž	Physicle this ceri at direct	ဥ	1 Yes 2 No	ospital: 1 Inpatient 2 ER/C			ome 5 Residence		HUSINOC
Ē	Jing P. After t funera	ë ë	27. Mann of Death 1 DNatural 5 ☐ Pending	28a. Date of Injury 28b (Month, Day Year)		Injury at Work?	28d. Describe how in	njury occurred	
sio	5 E : 0	cat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could ot be	20 50 41	М	1 Yes 2 No	Oof Landing (Change		10
Division	el or Attend s after death il Director: /	Certification;	4 Homicide det mined	28e. Place of Injury - At home, building, etc. (Specify)	tarm, street, factory, or	ice	City or Town, Si	and Number or Rura ate)	i Houte Number,
	To the Hospitel or Atta within 24 hours after de To the Funeral Directo completely filled in by th	edical (29a. Certifier (Check only one) 1 Certifying Physical Cartifier 2 Medical Examin	ician. To the cast of my knowled er: On the basis of examination a and manner stated.	ge, death occurred at the and/or investigation, in	ne time, date and place my opinion, death occu	and due to the cause rred at the time, date	and manner as s and place, and due to	lateu. o the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier	2	29c. Li	cense number	29d.	Date Jined (Month,	Day, Year)
	-		WAMINISTO	WAR MU	11/	19012		113/11	6
	12		30. Name and address of pereon who co	pleted cause of death (Item 23a	Y(Type, Print)	181	Balla	1 1/2	101011
	18		Van WITTYN	1 4211 1/1/18E	RUDDA	NY	MITIMA	110/10	412/8
	Sta		31. Date filed (Month, Day, Year)	32. Resistrar's Signature	-0-	,	-		-
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רוע	17 FROV 1/2				·				

ORIGINAL

Please Type or Print in Black Indelible Ink Thaddeus Anthony Bober State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 7, 2006 **Medical Examiner** Thaddeus A. Bober, Jr. 0844 hrs 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death 811 S. Bouldin Street Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs 7. Age (In vrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Director 220-48-6320 60 Jan. 17,1946 1 **X** M 2 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 28a-f show d at once. MD Baltimore 1 XYes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 811 S. Bouldin Street 21224 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black Armed Forces? White, etc. 1 X Never Married 2 Married 1 X Yes Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: White Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Diesel Mechanic Trucking 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Thaddeus A. Bober, Sr. Julia Olencz 19a. Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Ouidley- Sister Kirsim Court Freelend, MD 21053 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11-13-06 Baltimore.MD Stanislaus Cem. 4 Donation 5 Other Specify. 21. Sun ture of Funeral Service Licenses Charles S. Zeiler & Son, Inc. 6224 Eastern Ave. Baltimore,MD disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval ailure. List only one cause on each line Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease `xaminei or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner If any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED physician Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Dav Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Llokoowo Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital 1 Inpatient 2 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 8c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started ical (Check only within 2 **To the** 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. November 8, 2006 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Physician /Medical Examiner

Funeral Director

1 10000 1	State of Ma					Mental Hyg			06101
1 - State Registrar	State of Mi			tificate of			Reg. No.	UUb	36194
Decedent's Name (First, Middle, Last)						2. Date of Dea Month	ith Day	Year	3. Time of Death
Peter Lang B	rune					Nov.	12	2006	12:00 P M
4a. Facility Name (If not institution, give str	reet and number)			4b. City, Town, o	r Location of Dea	th	4c. C	County of Dea	ath
8608 Fluttering Le					denton			Anne A	runde1
5. Social Security Number 6. Sex	7. Ag и 2□F	e (In yrs. last birt		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)		rthplace (State or Foreign country)
013 30 7304		65	Yrs.			Apr 27,	194	1 Mas	sachusetts
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Lo	cation					10d. Inside City Limits
Maryland Anne Ar	unde1		Ode	enton					1 ☐ Yes 2√ No
10e. Street and Number				10f. Zip Code			10g. Citiz	en of Whal C	ountry?
8608 Fluttering Le	af Trail	Unit 3	307	21	113		U	nited	States
11. Marital Status	. Was Decedent Armed Forces?	Ever in U.S.	13. V	Was Decedent of H	lispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14		erican Indian,
1 ☐ Never Married 2 📆 Married	1 TYes 2 ☐!	No.		1 ☐ Yes 2 ∏rNo	Specify:	to rican, etc.)		Black, Whi	ite, etc.
3 Widowed 4 Divorced	Year or Dates:	1963-85		X100	Зреспу.		3	Specify:	white
15. Decedent's Educa (Specify only highest grade)		16a.	Deced (Give	ient's Usual Occup kind of work done	ation during most of wo	orkina	16b. Kind	d of Business	s/Industry
Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	DO NOT use retired -	d)			-	
17. Father's Name (First, Middle, Last)	4		<u>t</u>	Programs		ma (First Adidd)			y Company
	n					me (First, Middle,		umame)	
Raymond Frederick		401			Doroth	y Marie	Lang		
19a. Informant's Name/Relationship (Type		196.	Mailin	ng Address (Street	and Number or H	urai Houte Numbe	r, City or	Town, State,	Zip Code) 21113
Pamela Lowe Brune/	wile	The second second		STUTTERIN	g Lear 1	rail Uni			TON, MU
1 ☐ Burial 2 TCremation 3 ☐ Rei	noval from State	cemeter	y, crem	natory or other place	Nov.		200. LOG	anon - City of	10WII, State
4 Donation 5 Other (Specify)		West Ar		lel Crema		006		enton,	
21. Signature of Funeral Service			Dor	Name and Addre naldson F	ss of Facility uneral H	lome & Cr	emat	ory, P	.A.
230 Body Enter the disease or complice	nas that assess	the death. Do o				l, údento		0 2111	
23a. Part I Enter the disease, or complica shock, or heart failure. List only one	cause on each lin	10.	ot ente	er ine mode or dyir	ig, such as cardia	c or respiratory ari	est,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Non Sm	all Cell	. Lu	ing Cance	r				4 years
resulting in death)	Due to (or as	a consequence o	of):						
Sequentially list conditions, b.	D /								
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	or);						
that initiated events c. resulting in death) Last	Due to for as	a consequence o	vf)-						
	Due to (01 as	a consequence c	,,,						
d.									
IF FEMALE:	: If yes, outcome	of pregnancy							
in the past 12 months?	1☐Live birth	2 Fetal death		Ectopic pregnancy			23	3d. Date of de Month	livery Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or death	ο□	Other (specify)					
Part II. Dther significant conditions contr	ibuting to death be	ut not resulting in	the un	nderlving cause giv	en in Part I	23e. Did to	bacco us	e contribute t	o the cause of death?
		3		, and a second give			es 2 🗆		robably 4 Dunknown
						-			
						24a. Was a autops perfor	Sy	prior lo	utopsy findings available completion of cause of
							2 No	death?	s 2□ No
25. Was case referred to medical examiner?	spital:			Oth		ath (Check only or	ne)		
I Has ZIXIAO	1 🗆 Inpatie				4 🗆 Nursing r			Other (Spe	ecify)
27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injui (Month, Day		ime of ijury	28c. Injur	k?	28d. Describe h	ow injury	occurred	
2 Accident investigation 3 Suicide 6 Could not be	00 01 (1)	4.1			Yes 2 No				
4 ☐ Homicide determined	28e. Place of Injude	iry - At home, far c. <i>(Specify)</i>	m, stre	eet, factory, office		28t. Location (S. City or Town	treet and n, State)	Number or R	ural Route Number,
20a Codilion 400 a visit	inn T d					1			
29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	r: On the best of and manner sta	examination and	death Vor inv	occurred at the ting estigation, in my o	ne, date and place pinion, death occi	e, and due to the curred at the time, d	ause(s) a late and p	nd manner a lace, and du	s stated. e to the cause(s)
29b. Signature and title of certifier	anu manner sta	ilou.		29c. Licens					th, Day, Year)
Coll		1	1		533		, /	1.11	1
30 Name and address of person who com	pleted cause of d	MI	7) //		1//	14/0	

State Registrar

31. Date filed (Month, Day, Year) NOV 1 5 2006

Curtis Harris, Jr. M.D. 900 Bestgate Road Suite 300 Annapolis, Maryland 21401 32. Registrar's Signature

				ons 24a,25,26	lanyland 5,27,2	d Depa 29a per Cer	rtme Dr tifica	nt of Heal te of Dea	19.716/ ath	Mental Hy 06dhb	giene Reg. No.	2006	361	95
	Physici		1. Decedent's Name (First, Midd Ralph B. Car							2. Date of De Month	Day	3, 2(X)	3. Time of D	
	/Medio Examin		4a. Facility Name (If not institution		enti	er	4b. City	Town, or Loca	tion of Deatl			County of Dea		, r.
	Funeral Director		5. Social Security Number 216–16–0471	6. Sex 7. A 1 M 2 □ F	ge (In yrs. la 85	ast birthday) Yrs.	If Unde Months		nder 24 Hrs. urs Min.	8. Date of Bird (Month, Da Jan 17	th y, Year) , 19:	_ Co	thplace (State or Fountry) Tyland	Foreign
	inyland show	h.	Usual Residence of Decedent 10a. State 10b. Count		10c. City	, Town or Loc							10d. Inside City	
	the Ma	Director	MD Char	Les		LaP]		p Code			10a Citi	zen of What Co	1 Tyes 2	X No
	h with		305 Arlington	Drive					20646		rog. Oit.		SA	
36	urs efter deet ii', or iteme	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	12. Was Decedent Armed Forces 1 XYes 2 1	?] No	lf	Yes, sp	edent of Hispani ecify Cuban, Me	c Origin? (S	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, White Specify:	erican Indian,	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth and Mantal Hyglene. Department of Heelth and Mantal Hyglene importants if item 27 is marked other than "natural", or iteme 23a or 28a-f ehow empty injury or other treumatic event, I'm Marifeal Examinar must be inclined at annex.	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) UNK	nt's Education est grade completed) College (1-4or		16a. Deced (Give F	kind of w	ual Occupation ork done during use retired)	most of wor	unk king	16b. Kii	nd of Business	/Industry	unk
yland 2	ould be filed Mental Hygi arked other attic event,	To Be Co	17. Father's Name (First, Middle Francis Neal C	, Last) ary				18. N		n <i>e (First, Middl</i> e,		•	1	
Mar	d 2 shoth and the and treum treum	7 =	19a. Informant's Name/Relation Ada Cáry/s			1				ra <i>l Route Numbe</i> aPlata,		Town, State, . 20646	Zip Code)	
more,	Pages 1 an nent of Heel int: If Item 2 iry or other	8	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (3 □Removal from State		lace of Dispos emetery, crem	ation (Na	me of		Date		cation - City or	Town, State	
Balti	permit. Departm Imports eny inju		2) Signation of Euneral Service Roll Ltd	S. Wade, 13v	extor	_ St	ate	nd Address of F Anatomy ore, MD	Boarg	1 655 W.	Bal	timore	Street	
8760,	death certificate be executed Water and physicien and der use as the burial-transit	dical Examiner	23a. Part. Enter the disease, cancel of the shock of heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	s a conseque	tic quence of):	4	eno Co			Test,		Approximate Interval Betwe Onset and Dei	een ath
.O. Box 6	thet the death certific ed by the attending p detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal	death 3	Ectopic (pecify)			2	3d. Date of de Month	livery Day Yea	ar
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al Reco		e Completed	25. Was case referred to medic							1 ☐ Yes	rmed? 2 No	24b. Were as prior to death?	utopsy findings ava completion of caus 2 No	ailable se of
Division of Vital Records,	ding Phys .r After this funeral di	ToB	examiner? 1	Hospital: 1 Inpat		ER/Outpatient 28b. Time of Injury		Others	☐ Nursing H	ome 5 Resident	dence 6		cify)	
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director; Attecompletely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	mined 286. Place of Ir	njury - At ho	me, farm, stre	et, facto	ry, office		28f. Location (S City or Tox	Street and vn, State)	d Number or R	ural Route Numbe	or,
	Hospital 24 hours a Funeral stely filled	Medical	29a. Certifier 1 Certify (Check only one)	ng Physician: The basis I Examiner: On the basis and manner	of examinat	wledge, daeth tion and/or inv	occuma estigatio	Lat the time, dai n, in my opinion	ta and plans , death occu	and due to the red at the time,	dalies(s) date and	and manner as place, and due	stated, to the cause(s)	
)	To the within 2 To the complete	Med	29b. Signature and title of certific	aves !	fer			c. License num	ber 2019		29d. Date	signed (Mont	h, Day, Year)	
	Sta Registr		30. Name and address of person AMCS T HA 31. Date filed (Month, Day, Year NOV 1 6 200	RRING 10		MIEL	1	al stre	eet s	CULTE	02	LAPLA	G, C, M, AT	20646

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-22-06 vt. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Reg. No. 2006 36196 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Peter Reid Caudill November 14, 2006 1717 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months M 2□ F Director 218-46-2037
Usual Residence of Decedent 53 Apr. 24, 1953 Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f show the Wedical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Darlington Maryland Harford the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4033 Conowingo Road 21034 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 StNo þ Specify: 3 ☐ Widowed 4 ☐ Divorced White 11 | 14 | 06 Baltimore, Maryland 21215-00 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Car Service Center Mother's Name (First, Middle, Maiden Sumame) Oris Elaine Schaefer Lara Ruth Lapitina 17. Father's Name (First, Middle, Last) Doris Clara Be Mental Clifton Carnice Caudill Sr. ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 4033 Corowingo Road, Darlington, Maryland 21034
e of Disposition (Name of Date 20c. Location - City or Town, State B. Christine Caudill / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Depertment of H
Important: If Ite
eny injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 11-20-06 4 □ Donation 5 □ Other (Specify) Towson, Maryland 21. Signature Funer | Service Licensee 22 Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerofic **Physician** CARdibVasen lak one yeak /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coudill, Peter Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Wasan certificete has t irector, page 2 s 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ✓ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No the Director 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) o P within 24 hours after To the Funeral Dire o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Months November 15, 2006 d355 22 who mpleted cause of death (Item 2 a) (Type, Print) BEL AIR MARYLAND 21014 MARK Wild NORTH AVENUE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006

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			For Stata Registrar	State of Maryla		-	te of Dea			. No.	30131
	Physici	an	1. Decedent's Name (First, Middle, La				OHEN		Date of Death Month	Day Year	3. Time of Death
	/Medic	al	GILBERT 4a. Facility Name (If not institution, given	M street and number)			Town, or Locat		Novembe	r 14 2006 4c. County of Death	05:45 a ^M
	Examin	ier	Greater Baltimo		iter		vson	ion or boain		Baltimore	
	Funeral Director		5. Social Security Number 6. S 219-10-8987	7. Age (In yrs		day) If Unde	r 1 Year If Ur	ors Min. 08	Date of Birth (Month, Day, Y 3/22/192		nplace (State or Foreign unity) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town o	or Location					10d. Inside City Limits
	deeth with the Maryland ms 23a or 28e-f ehow r must be notified at	tor	MD N/A		BAL	TIMORE					1 Yes 2□ No
	th the	irec	10e. Street and Number			10f. Zi	ip Code		10g	. Citizen of What Co	untry?
	23a vi	aic	3 WEST MT. VERNO	N PLACE			21201			.s.A.	
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<u>Z</u>	should ind Men imarke	2	NATHAN 19a. Informant's Name/Relationship	JOSEPH	105.4	COHEN			Zouto Alumbos (City or Town, State, Z	BEYER
2 E	id 2 sl Ith and 27 le r treur		HELEN SCHLOSSBERG			-				10RE, MD 2	
is E	os 1 and 2 of Health of item 27 I		20a. Method of Disposition	20b.	Place of D	isposition (Na crematory or	ame of	Dat		c. Location - City or	
	Pages ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	Removal from State BAL	TIMÓF	RE HEBR	REW CONG		1000	REISTERSTO	CONTRACT DESCRIPTION OF THE PARTY OF THE PAR
Balt	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 le marked other then eny injury or other treumatic event, the MORE.		21. Signature of Coural Service Lice	N & BROS. KESVILLE,							
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the dea one cause on each line.	ath. Do no	t enter the mo		1	h	,	Approximate Interval Between Onset and Death
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eco	e law requ has been je 2 shoul	Completed							24a. Was an autopsy	24b. Were au	topsy findings available
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io	ittending I death. ctor: After ; the funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Inju	ury M	Work? 1 ☐ Yes	2 🗆 No			
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			For State Registrar	State of M	aryland .	/ Departme			and Mer		ene 006	361	98
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	Funeral Director		5. Social Security Number 145–64–5996	1 Y C7E 1 € 6. Sex 7. Ag 1 X M 2 □ F	e (In yrs. last 35	bihthday) If Un Yrs. Monti	der 1 Year ns Days	If Under a	Min.	Date of Birth (Month, Day, 1)	/ear) 9. Bir 1970 New	thplace (State ountry)	-
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Location						10d. Inside C	ity Limits
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	with th	Funeral Director	10e. Street and Number 5231 Brookway	Ant #1		10f.	Zip Code	044		109	g. Citizen of What C	ountry?	
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	s 1 and of Health Item 27 other t		20a. Method of Disposition		20b. Place	e of Disposition (etery, crematory)	Name of		Date		oc. Location - City or		
Baltimore,	Page Iment of tant: if Jury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.	ecity)		greene (Cemete	ry		-2006 н	illside,	Jew Jer	sey
Bal	permit. Pages I Department of H important: if Ite eny injury or ot once.		21. Signature of Funeral Service L	talma	~	Witz	and Addres ke Fur Twin	neral	Homes	Inc.	mbia, MD	21045	
			23a. Part1. Enter the disease, or o shock, or heart failure. List o fmmediate Cause (Final	omplications that cause nly one cause on each l	ine.		node of dyin	g, such as	cardiac or re	spiratory arres	it,	Approximation of the Approxima	ween
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Division of Vital Records,	The law requires thet the ate hes been signed by the page 2 should be detache	Completed			· · · · · · · · · · · · · · · · · · ·				[24a. Was an autopsy performe	prior to death?	utopsy findings completion of c	available ause of
Vita	Physicien: this certificatal director,	Be	25. Was case referred to medical examiner?	Hospital:			Oth		of Death (CI	neck only one			
of		n: To	1 ☐ Yes 2 📉 No 27. Manner of Death	28a. Date of Inju	ıry 28	Outpatient 3	DOA Othe	4 - 140			ce 6 Other (Sperinjury occurred	ocify)	
sion	Attending I r death. ector: After by the funer	catio	1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	ation		In j ury M	10	Yes 2 1					
Divi	sal or Attend s efter death al Director: ,	Certification;	4 Homicide determin	Zae, Flace of the	jury · Al home tc. <i>(Specify)</i>	, farm, street, fac	tory, office			City or Town,	et and Number or R State)	ural Route Num	ıber,
	To the Hospital or Atta within 24 hours efter de To the Funeral Directo completely filled in by th	-	29a. Certifier Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner st	of my knowle of examination ated.	dge, death occur and/or investigat	ed at the timion, in my op	ne, date and pinion, deat	d place, and th occurred a	due to the cau t the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s	5)
	To the To the Comp	Ž	29b. Signature and title of certifier	alcq, m	D		29c. License	redmun e	545	290	Date signed (Mon	th, Day, Year)	20
	5		30. Name and address of person w	no completed cause of a	death (Item 23	Ba) (Type, Print)	nh,	endi	MI	cay,	MD 21044		
	Sta Registr	te ar	29b. Signature and title of certifier 30. Name and address of person w 31. Date filed (Month, May, Year)	2006 32. R	rar's Signature	de appoint	ري				, , ,		

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Raymond Donnelle, Jr. Certificate of Death Registra Decedent's Name (First, Middle,Last) Raymond Donnell, Jr. 2. Date of Death Physician/ Month Day November 7, 2006 0611 hrs Medical Examiner Raymond Donnell Paymond Donnelle, Jr 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number Baltimore Sinai Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 6. Sex **Funeral** Months Days Hours Director Country) 51 217-64-5971 1 X M 2 F 08/05/1955 Usual Residence of Decedent 10b. County 10d Inside City Limits 10a. State Oc. City, Town or Location 1 X Yes 2 No MD Baltimore City hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 2604 Kirk Avenue 21218 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S. or items 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces? African American Yes 2 X No specify: Widowed Divorced If Yes. Give Year ş 16a Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DD NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 liment of Health and Mental Hygiene reant: If item 27 is marked other than "no or other traumatic event, the Medical E Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7. Department of Health and Mental Hygiene Important: If item 27 is marked other than retail Walmart 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname)

Raymond Donnell, Sr.

and manner stated

Assistant Medical Examiner

me and address o person who completed cause of death (item 23a)

2006

Laron Locke MD 31. Date filed (Month, Day,

19a Informant's Name/Relationship (Type, Print)

Donation 5 Other Specify:

Raymond Donnell, Sr. / Father

1 X Burial 2 Cremation 3 Removal from State

Physician /Medical xaminer

Be

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Division of Vital Records, P.O. Box 68760.

Medical Certification: To Be Completed by Physician/Medical Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit within 24 hours area constitution.

To the Funeral Director: After this centure.

21 Signature of Funeral Service Licensee	1 II- D 4								
///	meral Home, P.A. e, MD 21217								
23a Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	arrest, shock, or heart Approximate Interval Between Onset and Death								
Immediate Cause (Final disease or condition resulting in death) Hemopericardium Due to (or as a consequence of):	Death								
Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Ruptured aortic dissection of the control o	nd alcohol								
d									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Dther (Specify) 9 Unknown									
Part II. Other significant conditions contributing to death but not resulting	d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown								
	as an topsy findings available prior to completion of cause of death? 1 Yes 2 No No								
25. Was case referred to medical									
examiner? 1 Ves 2 No Hospital 1 Inpatient 2 ER/Ou	Residence 6 Other:								
27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. T	be how injury occurred								
1 Natural 5 Pending unkon unk									
3 Suicide 6 X Could not be determined (Specify) unkn	n (Street and Number or Rural Route Number, City n, State)								

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

20b. Place of Disposition (Name of cemetery

crematory or other place)

King Memorial Park

Barbara J. Donnell

20c. Location - City or Town, State

Randallstown, Maryland

29d Date signed (Month, Day, Year)

November 7, 2006

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2604 Kirk Avenue; Baltimore, Maryland 21218

11/17/2006

Date

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Owen Fellers November 6, George 2006 12:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Friends Nursing Home Sandy Spring Montgomery If Under 1 Year If Under Months Days Hours 9. Birthplace (State or Foreign Country) 1925 West Virginia Social Security Number 7. Age (In vrs. last birthday **Funeral** Year) 1 M 2 □ F Months 215-28-7225 81 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17200 Quaker Lane 20860 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ∑Yes 2 □ No If Yes, Give Year or Dates: [/ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Be Completed by 3 Widowed 4 Divorced WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engineer US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy Fellers Vivian Triplett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Fellers - Spouse 17200 Quaker Lane Sandy Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Hill Cemetery 11/8/06 Martinsburg, WV 22. Name and Address of Facility
Brown Funeral Home
P.O. Box 821 Mart 21. Signature of Funeral Service Licenses Martinsburg, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death mediate use (Final disease or condition resulting in death) **Physician** Hepatocellular Carcinoma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Line of Jernyling Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as IF FEMALE: use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) as been signed by the 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2□ No 1□ Yes 2 📉 No 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, within 24 hours after death To the Funeral Director:

> State Registrar

31. Date filed (Month, Day, Year) NOV 1 6 2006

Joseph Kaplan, MD

29b. Signature and t

30. Name and address of pe



on who completed cause of death (Item 23a) (Type, Print)

29c. License number

D35635

29d. Date signed (Month, Day, Year)

November 6, 2006

20832

State of Maryland / Department of Health and Mental Hygien 0 0 6 36201 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** DELORIS FRANKLIN 4:00 PM OCTOBER 25 2006 /Medical 4a. Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FT. WASHINGTON NURSING HOME PRINCE GEORGE'S FT. WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth MAY 13, 1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Days Months Hours EBON, TEXAS 93 466-30-0787 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itsm 27 is marked other than "natural", or Items 23s or 28s-f show other treumatic event, the Modical Example must be notified at 1√ Yes 2 No PRINCE GEORGE Directo MDFORT WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 921 AMER DRIVE U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: BLACK 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. 3yrs Elementary/Secondary (0-12) PRIVATE TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any liquy or other treumatic event SDRs. SYLVESTER MOORE SARAH USHERY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELOIS TURNER/NEICE 921 AMER DRIVE FORT WASHINGTON, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/17/2006 LOS ANGELES, EVERGREEN CEMETERY 22. Name and Address of Facility JB JENKINS FUNERAL 21. Signature of Funeral Service 7474 LANDOVER RD LANDOVER, MD 20785 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. 23a. Part1. Enter the disease, or co shock, or heart tailure. List on Approximate Interval Between Onset and Death Immediate Cause (Final Priysician END STAGE ALZHEIMERS disease or condition resulting in death) 6MONTHS /Medical Due to (or as a consequence ot): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence ot) Examiner The law requires that the death certificate be executed sate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical tF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 4No 2X No 1 Yes 1 Tes Hospital or Attending Physician: funeral director, 25. Was case referred to medicat Be 26. Place of Death (Check only one) examiner? Other. 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 24 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending after death. Director: Af 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of tniury - At home, farm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours at To the Funeral D completely filled is 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the E 29b. Signature and title of centified 29c. License number 29d. Date signed (Month, Dey, Year) D24535 10-31-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Laxmi N. Berwa M.D.

NOV 1 6 2006

31. Date filed (Month, Day, Yeer)

32. Rigistrar's Signature

7700 Old Branch Avenue C-101 Clinton, Maryland 20735

			1 - For State Registrar		State o	f Marylar		artment		lealth and	Mental H	(2006	36202	
				me (First, Middle, L	ast)			rimoute		304111	2. Date of D	Reg. No.		3. Time of Death	
	Physi		DORIS		Н				ED.	TEDMAN	Month	Day	Year	8:40 AM	
	/Med Exam	dical		(If not institution, gi		mber)		4b. City.		IEDMAN Location of Dea	Novem		County of Death		
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	Funera	al	5. Social Security I	Number 6.	Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 24 Hrs		irth	9. Birth	N/A place (State or Foreign intry)	
	Directo		219-05-	1837	1□M 2 F	86	Yrs.	Months	Days	Hours Min	(Month, D		Cou	intry) MD	
	pu »		Usual Residence of	1		10.0						<i></i>			
	arylan show	5	MD	10b. County	N/A	10c. CI	ty, Town or Lo BALTIN							10d. Inside City Limits	
	ith the M or 28a-f	Director		1	11/ /\		DALIIN							1X Yes 2 □ No	
		늄	10e. Street and Nu			OT T 1		10f. Zip				10g. Citiz	en of What Cou	intry?	
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	Itin	٠		5 Other (Speci		AMU	NO CON	G. . Name and	. Addros	11/15	/2006	BALT	LTIMORE, MD		
	Balti permit. Departri Imports any inju	3		MINIX	9Km	alu				EDETALIN	L LEVIN	SON 8	BROS.,	INC.	
6	The state of		23a. Part1. Enter t	the disease, or con art failure. List only	nplications that	aused the deat	h. Do not ente	er the mode	of dvina	LING I UWIN	COLUMN -	PIKES	VILLE,	MD 21208 Approximate	
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	/Medica		resulting in death)	ease or condition ulting in death) a. Liposarcoma Due to (or as a consequence of):											
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1	that the sed by detac	Y	Part II. Other signif	ficant conditions	contributing to de	ath but not resu	ulting in the un	nderlying cau	ıse giver	n in Part I.	23e. Did t	obacco use	e contribute to the	ne cause of death?	
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	DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ta	Medical	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exar	miner: On the pa:	sis of examinat	wledge, death ion and/or inv	occurred at estigation, in	the time my opir	, date and place, nion, death occur	and due to the red at the time,	cause(s) ar	nd manner as sta ace, and due to	ated. the cause(s)	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2 1 6 36203 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dealth Physician Month 14, M Goss November 2006 12:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 863 Jaydee Avenue Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 X F 217-26-6431 76 Yrs. February 13, 1930 Maryland Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location il Hygiene. . other then "netural", or items 23a or 28a-f ehow vent, the Medical Examiner must be notified as 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Directo Dundalk 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 3504 McShane Way 21222 **USA** Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed by 3XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Depertment of Health and Menfal Hygies
Important: If Item 27 is marked other ti
eny injury or other traumatic event, the 8 years Waitress Drug Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Royal Wheatley Sarah Peacock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Neel Daughter 863 Jaydee Avenue, Dundalk, MD. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 18 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, MD. 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P. 7110 Sollers Point Road, Dundalk, MD. A. 21222 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years conglet re /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month signed by the eld d be defached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? diserse 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown peed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificafe 1 Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 4 □ Nursing Home 5 □ Residence 6 X Other (Specify) Daughter's 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours effer To the Funerel Dire To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D0060052 MD Nov. 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5200 Eastern Ave. 21224-2734 Baltimore MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 6 2006 Registra

			1 - For State Registrar	State of Maryla			of Death	-	giene 0 (16 36204
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	Examir Funeral Director	ier	811 Fairfield Av 5. Social Security Number 6.5	enue	rs. last birthday) 2 Yrs.	West If Under 1 Y	ninster	s. 8. Date of Bird	Carro	
	ehow	7.	10a. State 10b. County MD Carrol		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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136	72 hours after deeth with the Maryland naturel; or iteme 23a or 28a-f ehow dical Ezar, ber must be notified at	by Funeral	811 Fairfield Ave 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent If Yes, specify 1 ☐ Yes 2🎇	21157 of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No no Rican, etc.)	14. Race Black	SA - American Indian, c, White, etc. White
51215-0036	within ne.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation	(Give	DO NOT use re	one during most of wo	orking	16b. Kind of Bus	
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aryii	2 should be and Menta le marked aumatic ev	To	19a. Informant's Name/Relationship	Турө, Print)	19b. Mailii	ng Address (St	reet and Number or F			
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Baltı	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice Ronald S.	Wader Sirect	St St	2. Name and A cate Ana lltimore	ddress of Facility atomy Boar MD 212	d 655 W.	Baltimo	re Street
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o uo	Attending Physician: The lav r death. ector: Atter this certificete has by the funeral director, page 2	atlon: T	27. Manner of Death 1	28a. Date of Injury (Month, Day Year	28b. Time o Injury	f 28c.	Injury at Work? 1 \(Yes \(2 \) No		how injury occurre	And of the state of
DIVIS		Certification:	3 Suicide 6 Could not to determined			reet, factory, of	fice	28f. Location (S City or Tox	Street and Numbe wn, State)	or Or Rural Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Directompletely filled in by	edical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medicat Exa	hysician: To the best of my l miner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the vestigation, in	ne time, date and place my opinion, death occ	ce, and due to the curred at the time,	cause(s) and man date and place, a	nner as stated. nd due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	. /// /			cense number		1	(Month, Day, Year)
			30. Name and address of person who	completed cause of death (I	7110 tem 23a) (Type,	Print)	43773		11/13/	2006
	Sta Regist		31. Date filed (Month, Day, Year)	a. a. a. a. a. a. a. a. a. a. a. a. a. a	88 Poo	K Ros	ed, West	min ste	r, mo	21157

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 935 AM SIRCOINE 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harborside Harford Gardens Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) unk **Funeral** Months Days Hours Min 1 ☐ M 21 F Yrs. 87 Nov 14, Director 212-22-6012 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other than "netural", or Iteme 23a or 28e-f show other treumstic event, the Marked Examination ust by motified at 1√2 Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4700 Harford Road 21214 USA Be Completed by Funeral unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♥ No Specify: If Yes, Give Year or Dates: black permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", any Injury or other treumatic event, The Mental Exagnes. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harborside Harford Gardens 4700 Harford Road Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 ☒Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

Approximate 21. Signature of Euneral Service Licensee Wade Director 28a. Part Enter the disease, or complica shock or heart failure. List only one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HTHEROSCLEROTIC **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Certification: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) burial-transit the attending physician and Due to (or as a consequence of) as the IF FEMALE 23c. If yes, outcome of pregnancy
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The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, has or Attending Physician: ierel Director: Atter th death.

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifia 29d. Date signed (Month. Day, Year) and title of certifier 29c. License number 29b. Signatus NOVEMBER D0060560

NEUK RD.

109

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a

Medical

PANKAJ LIKETERPAT

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

32.

BACK

Registrar's Signature

RIVER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of iv	iaiyiaiiu		rtificate of				g. No.2 ()	06	36206		
T	Physici	an	Decedent's Name (First, Middle RICHARD	e, Last) JEROME GE	r 7					te of Death			3. Time of Death		
4	/Medic Examir		4a. Facility Name (If not institution				4b. City, Town, o	or Location		ember	10, 20 4c. County		12:40A [™]		
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E	Funeral Director		5. Social Security Number 215-14-9997	404 005	ge <i>(In yrs. last</i> 38	t birthday) Yrs.	If Under 1 Year Months Days	Hours Hours	Min. Min.	te of Birth onth, Day, 1 St 17	Year) 1921	9 Birthp Cour Mary	lace (State or Foreign try)		
30	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation				,		0d. Inside City Limits		
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	s 23a nust k	Funeral Director	5919 Falkirk Ro		Ever in U.S.	10.3	21239		2.5-0.40		USA	A			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married XX Marr 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces XX Yes 2 ☐ If Yes, Give Year or Dates:	No WWII		Was Decedent of H f Yes, specify Cub I ☐ Yes XX No	an, Mexic Specif		es or No- etc.)		k, White,	an Indian, etc. i ite		
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_	10		30. Name and address of person	Will W	1) (Helm 23)	65 N	Charles	St	Touson	M	142	4			
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DHMH 17 Rev 1/2001

		State of Maryland / Department of Her State Registre Amend #8 Per FH G861 11/28/06 Certificate of De 1. Decedent's Name (First, Middle, Last)	eath Reg. No. 006 36207
Physici		Maria Gikas	Month 1 13 2006 9 30 P
/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	
		Harborside Herford Garden. Baltimor	re MD
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year II Months Days 1	t Under 24 Hrs. 8. Paragonaire Q32 9. Birthplace (State or Foreign Country) 2 15 15 15 15 15 15 15 15 15 15 15 15 15
ath with the Maryland 23a or 28a-f show ust be inclifted at	tor	Usual Residence of Decedent	10d. Inside City Limit
th the or 28a	irec	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
th wit	ai D	4213 Powell Avenue 21206	U.S.A.
ler des Items	by Funeral Director	1 Never Married 2021 Married 1 Yes 2021No	anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
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yland ould be fif Mental H warked ott	To Be	Lambros Lambrinos	B. Mother's Name <i>(First, Middle, Maiden Sumame)</i> Efrosini
		Petros Gikas, husband 4213 Powell Aver	Number or Rural Route Number, City or Town, State, Zip Code) nue, Baltimore, MD 21206
S = 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Daltimo Dermit. Page Department c Important: If any injury or		4 ☐ Donation 5 ☐ Other (Specify) Dak Lawn Cemetery 21. Signature of Euners Service Licenses 22. Name and Address of	Nov 17 2006 Baltimore, MD
Dermi Depariment any in		6415 Belair	of Facility, Miller-Dippel Funeral Home, Inc. Road, Baltimore, Maryland 21206 such as Cardiac or respiratory arrest, Approximate
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Fo th Mithin Fo th	Me	29b. Signature and title of certifier 29c. License nu	umber 29d. Date signed (Month, Day, Year)
			464 11/13/06
j j		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOA/IS A - HAS HM1 MD, S21 N. Swilms	St Forte 308 Baltmax MD 41
Sta R egistr		31. Date tiled (Month, Day, Year) NOV 1 6 2006 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **Physician** /Medical **Examiner** GUNTARDP **Funeral** Director To Be Completed by Funeral Director

- For		State o	f Maryl	and / D	epa	artment of h	lealth	and N	lental Hy	/gien	e _	0.0	000	0.0
1 - State Registrar					Cei	tificate of	Death	7		Reg. N	2 U	06	3620	18
Decedent's Name (First	t, Middle, La	ist)							2. Date of D	eath Da	21/	Year	3. Time of De	
James E.	Gunth	cop							NOVEM			2006	10:40	Ам
4a. Facility Name (If not in			2 4	_		4b. City, Town, o		of Death		40	c. Count	y of Death)	
	pital		h mor	2		Baltin		Cit	7					
5. Social Security Number	6.	Sex 11 M 2□F	7. Age (In)	yrs. last birt		If Under 1 Year Months Days	If Under	Min.	8. Date of B (Month, D)	9. Birth	place (State or F intry)	-oreign
216-30-5389 Usual Residence of Dece				73	rs.			1	08/12/	1933		L	MD	
	County		10c.	City, Town	or Lo	cation							10d. Inside City	Limits
MD						D-1	1 4 2 4 4 4 4		1. 1			-	1 ☐ Yes 2	. □ No
MD 10e. Street and Number						10f. Zip Code	ltimore	e, Mar	yland	10g. C	itizen of	What Cor	Intry?	
5502 Price A	wenue							21215			17	SA		
11. Marital Status		12. Was Dece	edent Ever i	n U.S.	13.	Was Decedent of I	lispanic O	rigin? (Sp	ecify Yes or N	0-	14. Fla	ce - Amer	ican Indian,	
1 Never Married 2	X Married	Armed Fo	2 X No			f Yes, specify Cub			Hican, etc.)			ick, White		
3 ☐ Widowed 4 ☐ D	ivorced	If Yes, Gir Year or D				1∐ Yes 2∭X No	Specify	:			Specil	y: Atr	lcan Ameri	can
	ecedent's E	ducation ade completed)		16a.	Deced (Give	dent's Usual Occup	ation during mo	st of work	ina	16b. l	Kind of E	Business/I	ndustry	
Elementary/Secondary	(0.12)	College (I-4or 5+)		life. I	DO NOT use retire	d) -							
6th	11:11/11/11		<u> </u>			labore		- 4. 61	. (5			Compar	ıy	
17. Father's Name (First, I			_				18. Moth	ers Nam	e (First, Middl			,		
10.14		rd Gunthro	p	101			1.01		Lillia					
19a. Informant's Name/Ro Armenta T. G				196.		ng Address (Street 5502 Price						, State, 2 21215		
20a. Method of Disposition) / WITE	20	b Place of		sition (Name of	Tiveria		Date				own, State	_
1 🎇 Burial 2 □ Crer	mation 3 (cemeter	y, crer	natory or other pla	ce)							
° 4 □ Donation 5 □ C				Woodla		Cemetery Name and Addre	on of Engil		/2006				yland	
21. Signature of Funeral	Same cice	msee	*		24				t; Balti				21217	
23a, Part1. Enter the dise	9359 01 001	onlications that of	aused the o	feath Doin	ot ent						124.	, Land	Approximate	
shock, or heart failu	re. List on	one cause on e	ach line.	Joann. Bor	iot orit	0	-			arrost,			Interval Betwe Onset and Dea	
Immediate Cause (Final disease or condition resulting in death)		a (oron	ary	-	Hrtery	D	1 Sec	ree				10 yea	NS
	ſ	Due to	(or as a con	sequence	of):									
Sequentially list condition if any, leading to immedia	ns,	b. — Due to	(or as a con	sequence o	of):									
Cause (Disease or injury	~													
that initiated events resulting in death) Last		c Due to	(or as a con	sequence	of):									
	·	. d												
IF FEMALE: 23b. Was decedent pregr	nant	23c. If yes, ou	tcome of pre		2	Ectopic pregnanc	,				23d. Da	ate of deli-	/ery	
in the past 12 month 1 ☐ Yes 2 ☐ No	ns?	4□Pregr	ant at time			Other (specify)	,			İ	M	onth	Day Yea	ar
9 🗆 Unknown		9□ Unkn	own											
Part II. Other significant		-	eath but not	resulting in	the u	nderlying cause gr	en in Part	I.	23e. Did	tobacco	use con	tribute to	the cause of dea	th?
Hyperter	nsion	1							1□	Yes 2	No	3 Pro	babiy 4 📈 Unk	nown
Diabetes	me	llitus							24a. Wa	s an			opsy findings ava	
									per 1 Yes	ormed?		death?	ompletion of caus	Se OI
25. Was case referred to	medical	l-:					26. Plac	e of Deat	h (Check only		-		20110	
examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1	Inpatient	2 ☐ ER/Ou	tpatien	t 3 DOA	er: 4 🗆 N	ursing Ho	me 5 Res	sidence	6 □Otl	her (Spec	ity)	
27. Manner of Death	Pending	28a. Date (Mon	of Injury th, Day Yea	28b. T	ime of njury	28c. Inju Wo	y at		28d. Describe					

Medical Certification: To Be Completed by Physician/Medical Examiner No tre within 24 hours after deau... To the Funeral Director: Aft

To the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

JAMES

Patient knewn as

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or iten any injury or other treumatic event, the Madical Examinat.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

2 Accident 6 Could not be determined 3 Suicide 4 Homicide

29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

K. A. Zaman,

29c. License number RES-000 29d. Date signed (Month, Day, Year) November 9, 2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. ZAMAN KAZI MBBS,

HOSPITAL OF BALTIMORE

State Registrar

31. Date filed (Month, Day, Year) NOV 1 6 2006



			1 - For State Registrar	State of Mary		artment e <i>rtificate</i>				giene	006	36209		
	Physici /Medic		1. Decedent's Name (First, Middle, La LATAS MA	si) Iinique	Garn	es			2. Date of Dea Month		Year	3. Time of Death		
	Examir		4a. Facility Name (If not institution, giv Mercy Medica	1 Center		Ba	Itimo				ounty of Death			
	Funeral Director		5. Social Security Number 212-96-6573 Usual Residence of Decedent	ex 7. Age (In	yrs. last birthday 26 Yrs.	Months		urs Min.	8. Date of Birtl (Month, Day 10/09/	Year) 1980	9. Birthp Cour	place (State or Foreign htry) MD		
	Maryland -f ehow	tor	10a. State 10b. County	100	c. City, Town or I	ocation	Baltimo	ore City			1	0d. Inside City Limits 1 Yes 2 No		
	with the	Director	10e. Street and Number 901 West Saratoga	Street		10f. Zip (Code 21223	2		10g. Citize	n of What Cour	ntry?		
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. or it ferm 21 is marked other than "natural", or items 23a or 28e-f ehow or other traumatic event, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 2 No If Yes, Give Year or Dates:	in U.S. 13	. Was Decede If Yes, speci	ent of Hispani fy Cuban, Me		ecify Yes or No- Rican, etc.)		USA Race - Americ Black, White,			
Maryland 21215-0036	thin 72 hours.	Completed b	15. Decedent's En (Specify only highest grade) Elementary/Secondary (0-12)	ducation	(Giv	edent's Usual e kind of work DO NOT use	done durina	most of worki	ng		of Business/Ind			
d 2:	filed wi Hygien other th	Be Con	12th 17. Father's Name (First, Middle, Last,			wareho		Mother's Name	(First, Middle,		te-Aid Imame)			
rylan	should be ind Mental I marked o	To B	John (Garnes	10h Mai	line Address	(0111-1)		Rosetta Sn	Smith ber, City or Town, State, Zip Code)				
Σ,	end 2 sl ealth and n 27 ie r		Rosetta Smith / N	Nother	120	5 Harlen	n Avenue		ore, Mary			Code)		
Baltimore,	Pages 1 ent of Hi ht: If Iter ry or oth		20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	Ob. Place of Disp cemetery, cre Trinity C	ematory`or oth	e of ner place)	11/18/	2006		tion - City or To nore, Mar			
Balti	permit. Pages 1 end 2 Dep.rtment of Health a Important: if Item 27 is any njury or other tra		21. Signature of Funeral Service Licer			22. Name and		acility Wy	lie Funer	al Hon	æ, P.A.			
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not er				Baltimore r respiratory arr		land 21	217 Approximate Interval Between		
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cardlof Due to (or as a co	Dulmoy	ary	arres	st				Onset and Death		
F	cate be executed minutes and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor	atrons	of s	iclete	e Cell	disea	ase_		hours		
.O. Box 687	Ine law requires that the death certificate site has been signed by the ettending physpage 2 should be detached for use as the	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☑ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4☑ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pred □ Other (spec				230	f. Date of delive Month	ry Day Year		
rds, P	w requires that been signed b should be dete	d by P	Part II. Other significant conditions of	ontributing to death but no	t resulting in the	underlying cau	use given in P	Part I.		oacco use		e cause of death?		
Vital Records,	ilcien: The law re certificete has bee rector, page 2 sho	Completed							24a. Was a autops perform	v	prior to con death?	osy findings available inpletion of cause of		
<u> </u>	rnysicien: this certific al director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	Hospital:	2 🗆 ER/Outpatie	nt 3□ DOA	Othor		Check only on		Other (Specify	·)		
Division of	ath. or: After the funeral		27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time (Injury	of 286	c. Injury at Work? 1 Yes		8d. Describe ho	w injury o	ccurred			
DIX	to the rospital or Attending Projectent: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	building, etc. (Sp					City or Towi	n, State)		Route Number,		
:	P Hosp 24 hou Fune Hetaly fil	Medicai	29a. Certifier 1 Check only one) 1 Certifying Ph	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, dea mination and/or i	th occurred at nvestigation, in	the time, dat n my opinion,	te and place, a death occurre	nd due to the cand at the time, d	ause(s) an ate and pla	d manner as sta ace, and due to	ated. the cause(s)		
,	within To th	Ž	29b. Signature and title of certifier	W MD			Dlo4	6666			igned (Month, D			
	2		30. Name and address of person who		(Item 23a) (Type	Print)				OVEII		2004		
	Sta		31. Date filed (Month, Day, Year)	Place 32. Registrar's S		ITIMOI	re, M	را، ط	1202					
	Registr	ar	NOV 1 6	2006 Magaz	1 1 Km	COMPANY.	P							

Please Type or Print in Black Indelible Ink 06-08574 State of Maryland / Department of Health and Mental Hygiene Timothy Calvin Grauel 2006 36210 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day November 11, 2006 0236 hrs Medical Examiner Calvin Graue1 Timothy 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death **Baltimore County** Dundalk I-695 Inner Loop to Trappe Road If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Months Davs Hours Country) Maryland Directo 1 XM 2 F 43 Yrs March 6 1963 220-96-2415 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location Any 1 Yes 2 X No Gambrills notified at once. Maryland Anne Arundel filed within 72 hours after death with the Maryland Director 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number United States 21054 615 Neff Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married Yes f Yes. Give Year 1 Yes 2 X No specify: Specify: White Widowed 4 Divorced item 27 is marked other than "natural", r traumatic event, the Medical Examiner "natural" è r Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Self-Employed Concrete Contractor 11 and Mental Hygiene 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be G. Milligan Calvin Cissel Graue1 Ann Pages 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 615 Neff Drive Gambrills, Maryland 21054 Elizabeth Diane Grauel/wife of Health 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place 1 X Burial 2 Cremation 3 Removal from State East New Market, East New Market Cemetery 11/15/2006 Maryland Donation 5 Other Specify 22 Name and Address of Facility
Donaldson Funeral Home & Crematory, P
1411 Annapolis Road Odenton, Maryland Signature of Funeral Service Licensee sanita Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) events resulting in death) Last certificate be executed and Physician/Medical UNPENDED AMENDED attending physician 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö ģ 1 Yes 2 No 3 Probably 4 Unknown ۵ Completed Records, 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No certificate 26 Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other₄ examiner? ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other Scene Inpatient 2 1 🗸 Yes ٩ 28a. Date of Injury 28c. Injury at Work' 28d. Describe how injury occurred 28b. Time of Injury After Manner of Death Driver auto fixed object collision o Nov 11, 2006 0225 hrs Natura Division Yes 2 🗸 No Pending the To the Funeral Director: 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) I-695 Inner Loop @ Trappe Road, Dundalk, MD Suicide determined (Specify) Interstate/Express Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated

0

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Pamela E. Southall, MD

30 Name and address of person who completed cause of death (Item 23a)

2006 5

Assistant Medical Examiner

32. Registrar's Signature

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 11, 2006

06-08406 Cullen B. Hinton -

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 36211

		1- For State Registrar		Certifi	icate of	Death		75	Reg No		0 3021
Physic Medical Exar		1 Decedent's Name (First, Mic						Date of D Month			3. Time of Death
wedicai Exar 	ninei	Cullen Bren 4a. Facility Name (if not institut			1.0	0:1		Novemb	per 6, 2	2006	0415 hrs
		Prince George's Hos	· - · · · · · · · · · · · · · · ·		41	Cheverly	r Location of	Death		c. County of Deal Prince Georg	
Funera	1	Social Security Number	<u> </u>	(In yrs. last b	pirthday)	If Under 1 Yea	ar If Under	24Hrs. 8 Date of		1/DD/YYYYY 9. 8i	
Directo		239-13-4760		44	Yrs.	Months Day		Min	,	Forei	
		Usual Residence of Decedent		· ·	113.	L		Apri	T T +	,1902	
any		10a. State 10b Count	/	10c. City, Tov	vn or Locatio	n					10d. Inside City Limits
Aaryland 28a-f show	5	MD Princ	ce George	Fores	tvill	e					1 X Yes 2 No
Maryl 28a-f	Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Cou	ntry?
th the Maryland 23a or 28a-f sho	🗖		venue			20747	7		US	SA	
th wit	Funeral	11. Marital Status 1 X Never Married 2 I	12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was	Decedent of His	spanic Origin	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Amei White, etc.	ican Indian, 8lack,
er dea	Fu		1 Yes 2	X No				dorto Modri, Cto.)		ъ.	a alv
ırs aftı u ral "	<u>ة</u>	45 Basedarda Education (0	ivorced If Yes, Give Year or Dates:	oleted) 16s		res 2 X No		nd of work done	Itch	Specify: D - Kind of 8usinessi	Lack
3036 within 72 hours at iene ter than "natural Medical Examin	Completed	Elementary/Secondary (0-12			during mos	st of working life	. DO NOT u	se retired)	TOD.	Kind of business	industry
036 tthin in	du	12			Labore	r			Re	staurani	
5-0 led w Hygie other	l ŏ						18.Mother's	Name (First, Middle	, Maider	Surname)	
21215-0036 Uld be filed within 7 Mental Hygiene marked other than forester, the Medica	Be	Cullen Mallor	•					adine Hin			
D 2 Should and M	ြို	19a. Informant's Name/Relation						er or Rural Route N			
10re, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene It fiften 27 is marked other than "natural", or items 23a or 28a-f she other tranmatic event, the Medical Fyaminer must be anotified at once		Loistine Mall	ory (Aunt)			on (Name of ce		orestvill Date		Location - City or	
3		1 X Burial 2 Cremation	on 3 Removal from Stat	e crem	atory or othe	r place)				ŕ	
Baltimore, permit Pages lat Department of Hee Important: If the		4 Donation 5 Other 5		Green		Cemeter		11-11-06		rboro, N	
Ba perm Depa Impe		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dickey's Funeral Se PO Box 1428, Hwy 111 North, Tarboro								rvice, Inc.	
Physician	1	23a, Pa. I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart									Approximate Interval
/Medica	1/	fail re. List only one caus Immediate Cause (Final diseas	e on each line.								Between Onset and Death
Examine	_	or condition resulting in death)	Due to (or as a consec		011 011077						
	_	Sequentially list conditions,	b								
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consec	quence of):							
d d	xan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	quence of):							
3760, ficate be executed g physician and s the burial - transit			d						_		
760, cate be execut physician and the burial - trai	n/Medical	UNPENDED	AMENDED								
	M/G	IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes, outcome		y 2 Fetal	death 3	Ectopic p	oregnancy	23	d. Date of delivery Month	
Box 687 The death certification is the attending is	icia	past 12 months?	4 Pregnant at ti			r (Specify)		a ognarioy		MOHAT L	Day Year
Box ne death of the attenual	Physician		9 Unknown								
Records, P.O. Box 68 The law requires that the death certi cate has been signed by the attendin neare 2 should be detached for use an	by F	Part II. Other significant condi	tions contributing to death i	but not resulti	ng in the und	derlying cause g	given in Part				the cause of death?
rds, I requires been sig hould be								24a. Wa			ably 4 Unknown
cords, law requir	ompleted							auto	opsy formed?	prior to d	topsy findings available ompletion of cause of
	S							1 🗸 Yes	2 N	o death?	s 2 No
ital ician: s certi	Be	25. Was case referred to medic examiner?	Hospital:	, a d 504			Other	heck only one)	7		
Division of Vital Records, tal or Attending Physician: The law requires after death all Directors. After this certificate has been seled in by the funeral director, page 2 should led	유	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	2 V ER/0	. Time of Inju		y at Work?	Nursing Home 5 28d. Describe	Reside	-	·
on C nding tth r: Af	io	1 Notural	(Month, Day,Yea	ar)		·	res 2 N	1	s riow inju	ary occurred	
riSic r Atte er dez irecto	fical		estigation 28e. Place of Injur	ry - At home,	farm, street,	factory, office b	uilding, etc.	28f. Location	(Street a	nd Number or Ru	al Route Number, City
Divisior Spital or Attend hours after death meral Director:	Certification:	Odioloc	ermined (Specify)				-	or Town,			1/2
Hosp 24 ho Fune stely f		29a. Certifier 1 Certifying F	hysician: To the best of my l	knowledge, de	eath occurred	d at the time, da	ite and place	e, and due to the cau	use(s) an	d manner as start	ed
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filed in by the limeal director,	Medical	one) 2 Medical Exa	aminer: On the basis of exami and manner stated	nation and/or	investigation	n, in my opinion,	, death occu	rred at the time, date	and pla	ce, and due to the	e cause(s)
->-	Ž	29b. Signature and title of certifi				29c. License			29d. [Date signed (Mor	th, Day, Year)
		LAUDEI	HULLIU			O.C.N	M.E.		Nov	ember 7, 200	6
6		30. Name and address of person		,							
<u> </u>		0.1 5 . 5	sistant Medical Exami		Penn Str	eet, Baltimo	ore, MD 2	1201			
S Regis	tate strar	31 Date filed (Man Day, Year)	2006 32. Spiritran's	Signature	-	W =					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 36212 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Nov 11, 2006 2:00 pm Arland Hall /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Good Samaritan Nursing Center Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | Nov 10 , 9. Birthplace (State or Foreign Country)
Ohio 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 76 Director 052-20-5667 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f ahow worle 1 X Yes 2 □ No MD Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with annot of Health and Mental Hygiene.
ansi if item 27 is marked other than 'natural', or items 23a or ury or other fraumatic avent, it a Medical Exertifiat must be a ury or other fraumatic avent, it is Medical Exertifiat must be a 1601 East Belvedere Avenue 21239 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 (∆Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hall Doris E. Maycumber (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bryan Bishop - Guardian 2 N. Charles St., Suite 500, Balto., MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages ' Department of I Important: If Ite any Injury or of stree. 1 Burial 2 □ Cremation 3 □ Removal from State Nov 20, 2006 Pleasant Hills, Ohio Pleasant Hills Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. S mature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Ind. 6415 Belair Road, Baltimore, MD 21206 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician INFARCTION ACUTE MYOCARDIAL resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examine and & Due to (or as a consequence of): ettending physicien for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 DEctopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed

Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Diractor: After thi
completely filled in by the funeral

Be 2

Certification:

Medical

									24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to	medical						26.	Place of Deat	th (Check only one)	
examiner?	1	Hospital	1 ☐ Inpatient 2 ☐] ER/Outpatient	3 🗆 [DOA D	ther:	Nursing H	ome 5 Residence	6 □Other (Specify)
2 Accident	Pending investigation	28a.	Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Inju	iry at	2 No	28d. Describe how injur	
	Could not be determined	28e.	Place of Injury - At h building, etc. (Special		t, facto	ory, office			28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)
		ner: Or							, and due to the cause(s rred at the time, date and) and manner as stated. d place, and due to the cause(s)

29c. License number

D16619

29d. Date signed (Month, Dey, Year)

NOV. 13, 2006

30. Name and ad loss of person who completed cause of death (Item 23a) (Type, Print)

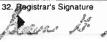
aunguntour MD

AVE. BALTIMORE, MD. 21239 1601 F. BELVEDERE C. VERGARA - SOARES 31. Date filed (Month, Day, Year)

ORIGINAL

State Registrar

29b. Signature and title of certifier





			1 - For Amend item#1, per	State of M MD,G861,11	laryland /16/06	/ Depa	artmer	nt of H te of L	ealth a Death	nd Me		iene 201	06	3621
	Physic	ian	1. Decedent's Name (First, Middle, Last Brennie Elias I	ackley, Jr	1						Date of Deat Month	h Day Ye	ear	3. Time of Death
Ì	/Medi Examii		4a. Facility Name (If not institution, give Johns Hopkins Bayvin		_	45		Town, or	Location of		vo vem	4c. County of i	Death	8133 AM
	Funeral Director		5. Social Security Number 6. Se		ge (In yrs. las 82	st birthday) Yrs.	If Unde Months	r 1 Year	If Under 2 Hours	Min.	Date of Birth (Month, Day, ul. 29	Year) 9.	Birthplac Country,	ce (State or Foreign
	the Maryland 28a-f ehow	ector	10a. State 10b. County Maryland Harfor 10e. Street and Number	đ	Joj	Town or Lo		p Code				0		Inside City Limits 1 ☐ Yes 25 No
9	s 1 and 2 should be tiled within 72 hours after death with the Maryland if Heelth and Mental Hyglene. Item 27 le marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Medical Exeminar must be notified at	Funeral Director	300 Fort Hoyle Rd 11. Marital Status 1 □ Never Married 2 ★ Married	• 12. Was Decedent Amed Forces 1 Tyres 2 [] If Yes, Give	?		Was Dece f Yes, spe	210 dent of Hi cify Cuba	spanic Origi n, Mexican,	in? (Specify Puerto Ric	y Yes or No- an, etc.)			Indian,
21215-0036	within 72 hours sne. then "natural",	Completed by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	Year or Dates: cation e completed) College (1-4or	5+)	16a. Deced (Give life.	kind of wo	al Occupa ork done d se retired,	uring most o	of working		Specify:		itry
Maryland 2	2 should be tiled within and Mental Hygiene. I e marked other ther raumatic event, I'm M	To Be Co	17. Father's Name (First, Middle, Last) Brennie Elias Haci	5+ kley Sr.		Scient	tific	:_Adv.	18. Mother			U.S. Gov Maiden Sumame) e Draper	ernm	ent
	1 and 2 should Heelth and Men tem 27 le marke sther traumatic		19a. Informant's Name/Relationship (Ty Ethel B. Hackley/ 20a. Method of Disposition				Fort	Hoyle	nd Number	or Rural Re Jopp	oute Number, Da, Mai	City or Town, Sta	.085	
Baltimore,	t. Page rtment or rtant: If	Owledge Control	1 ⊠Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature → Funeral Service Licens		сет	ietery, cren Lngtoi	natory or o n Nat	iona.	1 1	Date -29	-06 <i>I</i>	20c. Location - City Arlingtor		
Ä	Depa Impo Impo eny li		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	Duce 1 ications that cause ne cause on each i	d the death.	= 13	317 C	okes	oury F	Rd., 1	P. A. Abingdo	on, Marvl	Ap	21009 oproximate terval Between
	The law requires that the death certificate be executed by the attending physicien and in properties and in properties and in properties are the burial-transit and in properties and in properties are the burial-transit.	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as Corona Due to for as	a consequen	ery c			eng a	uncer			2	yeurs
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic pi Other (sp	regnancy pecify)				23d. Date of Month	delivery Day	y Year
ords, F	w requires that been signed I should be det	Ď	Part II. Other significant conditions con							rolemia	23e. Did tob	acco use contribut s 2 □ No 3 □		ause of death?
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on of	Phy this ald	Certification; To Bo	examiner?	ospital: 1 X Inpation 28a. Date of Injute (Month, Date of Injute (Month) (Month, Date of Injute (Month)	y Year) 28	VOutpatient Bb. Time of Injury	M 2	Other Sc. Injury Work 1 □ Y	4 ☐ Nursi	ing Home 28d.	Describe how	nce 6		
Div	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely tilled in by the funer	al Certif	4 ☐ Homicide determined 29a. Certifier	28e. Place of Inj building, et sician: To the best	of my knowle	dge death	occurred	at the time	a, date and r	place and	City or Town,	(so/s) and manner		
	To the Ho within 24 h To the Fu completely	Medical	29b. Signature and title of certifier	and manner st	f examination ated.	and/or inv	estigation	in my opi	nion, death	occurred a	t the time, dat	d. Date signed (Me	lue to the	cause(s)
•	1891		Service S.W. 30. Name and address of person who co	mpleted cause of c	eath (Item 23		Print)		-00C			dovember	で 5, 2	2006
	Sta Registr	te ar	Genevieve B Melton- 31. Data filed (Month, Day, Year) NOV 1 6 201	Meaux, 4	940 Ed ar's Signatur	Stern	Aveni	e Bo	utimon	e,Mo	21224		Colombia (Colombia)	

			1 - For State Registrar	Stat	e of M	aryland		artment rtificate				lental Hyg	iene	/ 1111	6	36215
			1. Decedent's Name (First, Middle, Last) 2. Date of Death										Time of Death			
	Physic /Medi		Elizabeth E. Hughes							Month 11/12	Day	Yea		:35 p.m. ^M		
	Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death							<u>++/</u>		County of De		. 55 p.m.		
			Golden Crest Asst	Living				Westminster				Carroll Cou		Cour	ntv	
	Funeral		5. Social Security Number	6. Sex		ge (In yrs. las		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,		9. E		(State or Foreign
	Director		245-30-2300	1 □ M 2⅓	3.5	85	Yrs.					1/29/				Carolina
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 Is marked other than "natural; or Iteme 23a or 28a-f show any figury or other traumatic event, the Madicial Examination must be nutified at ance.	Director	Usual Residence of Decedent 10a. State 10b. Coun	ty		10c. City,	Town or Lo	cation							104 1	nside City Limits
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and	ntal h	Be	Tr. Fallier's Name (First, Milotie	, Last)								(First, Middle, M	Maiden .	Sumame)		
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Maryland	d 2 s th an th an trau		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
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	ten fleath for:	cat	2 Accident investigation M 1 Yes 2 No													
≥		Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	Hospital or 24 hours afte Funeral Dir tely filled in	ledical Ce														
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
	within 2 To the complet	Me	29b. Signature and title of certific	and	manner st	ated.										
	F 3 F 3		250. Date signed (Month), Day, Year)													
,	-	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jehn W. Middleton & PSParle Rd Wyshmin 5th MO 21157													
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	Director		220–18–5804]M 2 2 €F	79 Yrs.	Months Days	Hours	Min. (Month, I March	Day, Year, . 15,	1927 Ma	rvland		
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	72,hours after death with the Maryland natural; or Items 23s or 28s-f ahow Iteal Examiner must be notified at	Funeral Director	10e. Street and Number 1301-F Cedar Cres	t Court		10f. Zip Code 21 040			_	itizen of What Cou ted State	•		
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Bal			21. Signature of Funeral Service Lioun	9 /1	22	. Name and Addre	ss of Facility	David J.	Webe	er Funera	al Homes PA		
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Division of Vital Records,	al or Attend after death I Director: / d in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm, str	eet, factory, office		28f. Location	(Street ar	nd Number or Run	al Route Number,		
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	Hospital 24 hours a Funeral D letely filled i	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best	of my knowledge, death of examination and/or inv	occurred at the tir	ne, date and p	place, and due to the	e cause(s) and manner as s	stated.		
	the H in 24 the F splete	edi	one)	and manner st	ated.	restigation, in my o	pinion, death	occurred at the time	a, date and	a place, and due t	o the cause(s)		
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•			<i>*</i>	TINY	1	000	5938	57	11,	13/06			
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State of Maryland / Department of Health and Mental Hygiene 2006 36217 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Paul John Jones 10:30 AM 2006 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 20, 1908 Birthplace (State or Foreign Country) **Funeral** 052-20-7053 1**X**0 M 2□ F 98 Director Yrs Sept. New York Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28e-f ehow 10d. Inside City Limits notified at N/AMaryland Director Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Exercise mest be 21210 628 Colorado Ave. United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" white ir than "natur Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) engineering/U.S. Govt. civil engineer other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mentai Archibald Jones Josephine Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 I Baltimore, MD 21210 Nell Jones/wife 628 Colorado Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of H Important: If Ite any Injury or ot poce. 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem. Nov. 13,2006 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licensee John O. 23a. pm1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Massive GI bleed minutes /Medical Due to (or as a consequence of): Examiner Respiratory arrest minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of). Physician/Medical use es the ed by the attending detached for use ex 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 been si Completed Prostate Cancer 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No s certificate has t lirector, page 2 s autopsy performed? Yes 2 X No 1 ☐ Yes director 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2XXER/Outpatient 3□ DOA To the Hospital or Attending Phys within 24 hours after death.
To the Funerel Director: After this completely filled in by the funeral di this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62551 November 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric J. Beauvois St. Joseph Medical Center 31. Date filed (Month, Day, Year) NOV 1 6 2006 32. Istrar's Signature State Registrar

			For State Registrar	state of Maryland		rtificate of L			Reg. No. 2 (106	3621
ij	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Della Marie King					2. Date of De Month November	eath Day	Year	3. Time of Death
4	Examin Funeral Director		4a. Facility Name (If not institution, give street Crofton Convalescers 5. Social Security Number 216-24-7333 6. Sex		st birthday) Yrs.	4b. City, Town, or Crofton If Under 1 Year Months Days		8. Date of Bir	4c. County Anne th ay, Year)	of Death Arunc 9. Birthplac Country	e (State or Foreigr
. ·	D	ctor	Usuel Residence of Decedent 10a. State 10b. County Pa York	10c. City,	Town or Lo			rep. 20	3 , 1917	Virgi 10d	nia Inside City Limits 1 □ Yes 2 🏋 No
	th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 885 Plank Road			10f. Zip Code 17349	9		10g. Citizen of V	Vhat Country	?
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the Az is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I □ Yes 2[X] No	ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)		e - American k, White, etc Whit	
0-0171	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Educat (Specify only highest grade c Elementary/Secondary (0-12) 12	ion ompleted) College (1-4or 5+)	16a. Deced (Give life. I	lent's Usual Occupi kind of work done o OO NOT use retired	ation during most of wor)	rking	16b. Kind of Bu		stry
ומוות ל	should be filed with nd Mental Hygiene. marked other thai imatic event, the I	To Be Co	17. Father's Name (First, Middle, Last) James Browning	0	Waltı	C55	18. Mother's Nan		, Maiden Surnam		
c, Mar	and lealth m 27 her tu	·	19a. Informant's Name/Relationship (Type: Flora Capps / Daugh	ter	885 E	g Address (Street and Road Road Street and Road Road Road Road Road Road Road Roa				19	
	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		1 M Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	noval from State	metery, crer 1 Have	natory or other place on Mem. Pa . Name and Addres . 107 Wilke	ark 11/1	18/2006 ubbard F	Glen Bur uneral H	nie, l	Maryland Inc.
ga.	The law requires that the death certificate be executed was labeled by the attending physician and unique 2 should be detached for use as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a conseque	Do not ent		g, such as cardiad			A	proximate leteral Between nset and Death
O. DOX	the death certi y the attending ched for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown	If yes, outcome pf pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dead 9 Unknown	death 3□	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of delivery nth Da	ay Year
COLUS, L	aw requires that s been signed b 2 should be deta	Completed by Ph	Part II. Other significant conditions contri	buting to death but not result	ting in the u	nderlying cause give	en in Part I.	1 □ 24a. Was	$\overline{}$	3 ☐ Probab	cause of death? ly 4 Unknown y findings available letion of cause of
אוומוו א	/siclan: The s certificate ha director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 Yes 10 Hos	pital: 1 □ Inpatient 2 □ E	R/Outpatien	t 3□ DOA Othe	26. Place of Dea	1 Yes ath (Check only	2 No 1	leath? □Yes 2[□ No
	To the Hospital or Attending Physiclan: The law within 24 butus after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s	Certification: T	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		28b. Time of Injury	28c. Injun Work		28d. Describe	how injury occurr	ed	loute Number,
2	Hospital or 24 hours afte Funeral Di etely filled in	Medical Cert	29a. Certifier 1 Certifying Physic	ian: To the best of my know r: On the basis of examination	ledge, deatl	n occurred at the tin vestigation, in my o	ne, date end place pinion, death occu	e, and due to the	cause(s) and ma	nner as state	ed. ne cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier		MD	29c. License		3	29d. Date signed	(Month, Da	y, Year)
1	1		30 Name and address of person who com	pleted cause of death (Item 2	23a) (Type,	Print) O B G A	LLANI	FOX L	N.30	Nie	MD

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

32. Registra s Signature

NOV 1 6 2006 >

State of Maryland / Department of Health and Mental Hygien $\mathbf{z} \cup \mathbf{U} \mathbf{b}$ For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month November 14, 2006 6:28 P M DAVID FRANKLIN KROFT, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County 703 Regester Avenue Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 15₹M 2□F Director 501-09-5797 1920 North Dakota 86 June Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r then "natural", or iteme 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore County Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 703 Regester Avenue death Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ∑ Yes, 2 □ No
If Yes, Give
Year or Dates:
1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No
1 ☐ Yes 2 ☐ No
2 ☐ No Specify: 11. Marital Status 14. Race - American Indian. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ Specify: White 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. other then College (1-4or 5+) Elementary/Secondary (0-12) Lieutentant Colonel (Ret.) US Army 4+ lith and Mental Hygie 27 is marked other r traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked oth enty injury or other traumatic event SDES. Chester Clyde Kroft Betsy Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Regester Avenue, Baltimore, Maryland 21212 Robin A. Kroft (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Green Mount Crematory Nov 15/2006 Baltimore, Maryland 21. Signature Juner June Woonboo 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC. awan Lawson 6500 York Road, Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). attending physicien and for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been si 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete has be rector, page 2 s 1 Yes 2[To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funars! Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 I Nursing Home မှ 1 ☐ Yes 2 ☑ No 5 Residence 6 Other (Specify) 27. Manner of Death Medical Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and ol certi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francis Mwaisela, MD, 120 Sister Pierre Drive, Suite 109, Towson, MD 21204

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 6 2006

32. Registrar's Signature

			1 - For State Registrar	State of	Marylan			of Health a of Death	and Men	tal Hygie	-ZHHb	36220
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Peter Vincent L A. Facility Name (If not institution,	opresti	er)		4b. City, Tov	vn, or Location o	N	Pate of Death Month Vember	Day Year // 200 (
			Good Samaritan 1 5. Social Security Number 220-05-8352		Age (In yrs.	last birthday) Yrs.	Balti If Under 1 Y Months Da		Min. (/	eate of Birth Month, Day, Ye	n/a ear) 9. Bir	thplace (State or Foreign ountry) v1and
	he Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD			y, Town or Lo	:					10d. Inside City Limits 1X Yes 2 ☐ No
	within 72 hours after death with the Maryland ene. than "natural", or iteme 23s or 28s-f show to Madical Exemiter coast ke inclined at	Funeral Dir	10e. Street and Number 4506 Arabia Aver 11. Marital Status	12. Was Decede	ent Ever in U.	S. 13.	10f. Zip Co. 212 Vas De cedent f Yes, specify		gin? (Specify) , Puerto Ricar		U.S.A. 14. Race - Ame Black, Whit	erican Indian,
15-0036	72 hours afte "natural", or l	þ	1 Never Married 2 Marrie 3 Widowed 4 Divorced 15. Decedent's (Specify only highest	If Yes, Give Year or Date		16a. Deceo	I ☐ Yes 2 📉 lent's Usual Or kind of work de	No Specify: ccupation one during most			Specify: Wh	ite
Maryland 21215-0036	Ibe filed within ntal Hygiene.	Be Completed	Elementary/Secondary (0-12) 7th grade 17. Father's Name (First, Middle, La Anthony Lopresti	*	or 5+)	Carpe	nter	18. Mothe		it, Middle, Maid	altimore den Sumame)	City
re, Maryla	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23s or 28s-f show any injury or other traumatic event, the Modical Exportment rounds be prefitted at ODGs.	To	19a. Informant's Name/Relationship John Lopresti, b 20a. Method of Disposition	(Type, Print)	20b. P	4506	Arabia	Avenue,		nte Number, Ci	ty or Town, State, 2 MD 21214 . Location - City or	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		Burial 2 Cremation 3 4 Donation 5 Other (Spe 21. Signature of Funeral Service Lie	cify)	Par	kwood		cy No	Mill	2006 I er-Dipp	Baltimore Del Funer	, MD al Home, Inc
	Physician /Medical		23a. Part Ener the disease or so shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. res	sed the death	ator		dying, such as o		piratory arrest,		Approximate Interval Between Onset and Death
8760,	cate be executed by sician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cciv	as a consequ	Lence of):	ton onte e he	ray c	Viseo Jail	rse ene		
O. Box 6	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor	me of pregna 2 Fetal t at time of de	ncy death 3	Ectopic pregna Other (specify	ancy	<i>Y</i>		23d. Date of del	ivery Day Year
ords, P.	The law requires that the de ite has been signed by the a page 2 should be detached f	Ď	Part II. Other significant conditions	s contributing to deat	h but not resu	ulting in the un	derlying cause	given in Part I.	2	3e. Did tobacc		the cause of death?
Vital Records,		Be Completed	25. Was case referred to medical examiner?					26. Place		4a. Was an autopsy performed Yes 2	prior to death?	topsy findings available completion of cause of
Division of V	ding Phys	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat			ER/Outpatient 28b. Time of Injury	28c. I	Other	sing Home :		6	sify)
S S	To the Hospital or Attent within 24 hours after death To the Funeral Director: cumpletely filled in by the	edical Certific	2 Interior	ad 286. Place of	etc. (Specify	vledge, death	occurred at the	e time, date and	Diace, and di	ity or Town, St	(s) and manner as	stated
)		Med	29b. Signature and title of certifier	and manner	stated.	-1D	,29c. Lic	ense number	5	29d. I	Date signed (Month	Day, Year)
	3		· · · · · · · · · · · · · · · · · · ·	955 in 82	NI	Euto	Print)	. #30	8 8	altim	ere, HD	2/201
	Sta Registr		31. Date filed (Month, Day, Year)	1 6 2006	strag Signat	ure A	back					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year 10n5 /Medical Jovember 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore, MC Paruland Medical N/A If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) Months 1 M 2 □ F Hours 07/05/1951 55 212-50-0664 MD Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at BALTIMORE BALTIMORE Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 Items 23a 6617 SHELRICK PLACE USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once. Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify <u>چ</u> 3 ☐ Widowed 4 🛣 Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 1 Elementary/Secondary (0-12) SALES PAINT 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) LYONS KRICHINSKY ALBERT ADELINE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7689 SILVER LAKE DRIVE - DELRAY BEACH, FL 33446 ALBERT LYONS / FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State FORBAND CEMETERY 11/15/2006 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mass Ler 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ultiorgan /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent of): Examine The law requires that the death certificate be executed nepatitis physician and s the burial-tran Due to (of as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury ours after death. neral Director; A filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Barrett

NOV 1 6 2006

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

November

Greene Street Baltimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Dav Year Andre Miles NOVamber 07, 2006
4c. Country of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Peninsuca SALISBULLY REGIONAL NICOMICE CONTA If Under 1 Year | Isonder 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 1□M 2□F Days 216-70-2210 Director 48 May 19, 1958 Maryland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ∏Yes 2 ☐ No TXHouston Houston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5735 Belcrest Street 77033 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder 12 Welding Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Way Ruby Miles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmira Fowler (Friend) 5735 Belcrest St. Houston, TX 77033 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South park Crematory | 11/20/06 Pearland, Texas 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eternal Rest Funeral Home 4610 S. Wayside Houston, a3a. Part1. Erfter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician CARDIOMYOPATHY CONCLESTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** LIVER FALLERE Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed RENTAL Much that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical F FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has performed? Yes 2 No certificate the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No Hospital: ပို 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

29b. Signature and title of certifier

NEYAL DOM! 31. Date filed (Month, Day, Year)

NOV 1 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

320 MILL POND # 712

32. Resistrar's Signature

Broke miles

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 36223 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year 6-42 PM 4a. Facility Name (If not institution, give street and number) larston 9+1 2006 /Medical Vovempe Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimor Ma 19rb01 Hospita If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year May 22, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1930 Pennsylvania **Funeral** Months Days 1 ☐ M 2 🗑 F Hours Min. 214-26-5303 Yrs. Director 76 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Director Anne Arundel 1 ☐ Yes 2 ☑ No Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7355 Furnace Branch Road Items 23a 21060 Funerai USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 0, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Specify: White þ 3 XWidowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 0 homemaker own home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Stanley Muir 2 virginia Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 le eny Injury or other trau Roland Duff/son 4408 Scotia Road Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Signature of Juneral Service 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 21201 Director 655 W. Baltimore Street in 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Ovarian Cancer 3 years /Medical Due to (or as a consequence of): Examiner PSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physiclen and s the burial-transit The law requires that the death certificate be executed - otenio-Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai Se esn ettending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 4☐Pregnant at time of death Dav Year signed by the et id be detached fo 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown should I 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate has t irector, page 2 s autopsy performed; 1 Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical Medical Certification: To Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.
To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature. State NOV 1 6 2006 Registrar

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	Funeral Director		246-44-3955		м 2 КО F	7. Age	71	Yrs.	Month		Hours	Min.	(Month,	Day, Year)	Cou	place (State or Fore intry) h Carolin	•
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7	mat in	Ph	Part II. Other significant cond	itions cor	ntributing to	death but	t not resulti	ing in the u	nderlying	cause giv	en in Part I.		23e. D	oid tobacco u	use contribute to	the cause of death?	,
cords,	urres r sign ld be	d by			-				,				1	☐ Yes 2	⊠ No 3 □ Pro	bably 4 Unkno	wn
כ	w require been si should I	Completed											24a. V	Vas an	24b. Were aut	opsy findings availa	ble
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:	withii To th	ž	29b. Signature and title of Cort	fier					2	9c. Licens	e number	- ^		29d. Da	te signed (Month	Day, Year)	
	/		Jo S	eu	ose	ee	an	~ M	· D	DA	122	3()		11-	-14-2	006	
	5		30. Name and address of pers	on who co	ompleted ca	use of de	ath (Item 2	3a) (Type,	Print)	600	435; 2,5; 21air	Ato	000	d'z	road	3	
18.	- C-		31. Date filed (Month, Day, Ye		1 1 1		r's Signatu	200	1	136	elai	82	1014				
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Physicia /Medic Examin	al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		Month	13	2004 unty of Death	910 PM
Funeral Director		Bon Secour Hospital 5. Social Security Number Compared to the second of Decedent Security Number Compared to the second of Decedent Second	(In yrs. last birthday)	If Under 1 Year Months Days	re City If Under 24 Hours	Min. 8. Date o	f Birth), <i>Day</i> , Year) 06/1926	9. Birthp Coun	lace (State or Foreigr try) MD
e Maryland	Director		10c. City, Town or Lo	cation Itimore Cit	у			1	0d. Inside City Limits 1 XYes 2 ☐ No
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a within 72 ho gione. r than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+	(Give	dent's Usual Occupa kind of work done o DO NOT use retired fireman	lurina most o	f working		of Business/Inc	dustry y Fire Dept.
should be filed nd Mentel Hygi marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Lawrence M. Miller			18. Mother's	Name (First, Mic Annie Th	ddle, Maiden Sui		L
l end 2 leeith a lee trai		19a. Informant's Name/Relationship (Type, Print) Steven Miller / Son 20a. Method of Disposition	20b. Place of Dispo		ta Road	r Rural Route No ; Baltimor Date	e, Maryla		3
permit. Pages 'Department of the important: if its any injury or of απος.		1 🖺 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Garrison F	orest Cemet Name and Addres 638 N. Gilm	ery 1:		neral Home		
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deeth certifi e attending I id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d.	Date of delive Month	ry Day Year
iaw requires thet the es been signed by th 2 should be detache		Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying fause give	Jes	_	Did tobacco use		e cause of death? ably 4 DUnknown
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page	atlon: To Be	25. Was case referred to medical examiner? 1 Yes		28c. Injury Work	9r: 4□ Nursi		12.5		<i>'</i>)
vital or Attaurs after de ral Diracto	Certification:	4 Homicide building, etc.				City or	on (Street and No Town, State)		
the Hosp thin 24 hou the Fune mpletely fi	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of and manner state 29b. Signature and fittle of certifier	ixamination and/or inv	occurred at the time restigation, in my op	oinion, death	place, and due to occurred at the ti	me, date and pla	ce, and due to	the cause(s)
A VAID		30. Name and address of person who complyted cause of de-	(Item 23a) (Type	Doo	3135	7		anso	13, 2006
Sta Registr		31. Date filed (Month, Day, Year) NOV 1 6 2006	Ba	ltimore,	MD 21	223			

Jeffrey Marrow 06-08594 UNK UNK

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State of Maryland / Department of Health and Mental Hygiene

ON CON		- For State legistrar	tate of Maryland	-	tificate of D		u Ment		eg. No.	2006	36228
Physician	1/	1. Decedent's Name (First, Midd						Date of Dea Month		Year	3. Time of Death
Medical Examine		Jeffrey Marro			1.05	City, Town, or	Leagter	Month Novembe		2006 County of Death	1931 hrs
		4a. Facility Name (if not institution Sinai Hospital	on, give street and number,			Baltimore	Location of	Deatt	40.	County of Death	
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. la		f Under 1 Year Months Day		24Hrs. 8 Date of Bi	rth(MM/I	DD/YYYY) 9. Birt Foreig	n
Director	-	unk Usual Residence of Decedent	1 X M 2 F		23 Yrs.	violitio Day	1100.0	10/03	3/198	3 Co.	untry) MD
, and	-	10a. State 10b. County	,	10c. City,	Town or Location	· · · · ·					10d Inside City Limits
f show	<u>.</u>	MD					ore Ci				1 X Yes 2 No
h the Mary 3a or 28a otified at	E L	10e. Street and Number 1004 West Most	ner Street			Of. Zip Code	21217			zen of What Cour USA	
21215-0036 Jud be filed within 72 hours after death with the Maryland Mental Hygene. gevent, the Medical Examiner must be notified at once.	ᇒᆝ	11. Marital Status 1 X Never Married 2 N	1 Yes 2		If Yes,	specify Cubar	n, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Americ White, etc.	
rs afte ural", miner	≥ -	3 Widowed 4 Dir 15. Decedent's Education (Spe	ivorced If Yes, Give Year or Dates: ecify only highest grade cor	npleted)	1 Ye	s 2 X No		ind of work done		Specify. Afric (ind of Business/li	an American
72 hou n "nat	- - - -	Elementary/Secondary (0-12)				of working life					Juda
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygene. Important: If tiem 27 is marked other than "natural"; injury or other traumatic event, the Medical Examiner.	Completed	10th	n/a			warehou				Fila	
15-(യ	17. Father's Name (First, Middle	e, Last) Marrow, Sr.				18. Mother's	Name (First, Middle, I Tammie I		,	
212 212 Wents Ments mark	라	19a. Informant's Name/Relations			19b. Mailing Ad	Idress (Stree	et and Numl	per or Rural Route Nur			Zip Code)
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Bal permi Depar Impo		21. Signature of Funeral Service	e Licensee			e and Addres N. Gilm		Wylie Fune eet; Baltimor	eral l e. Ma	Home, P.A. arvland 2	1217
Physician		28a. Part I. Enter the disease, o failure. List only one cause		the death.							Approximate Interval Between Onset and
/Medical 		Immediate Cause (Final disease or condition resulting in death)	_{e a.} Multiple Gunsh								Death
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Division of Vital Records, P.O. In the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the Completely filled in by the funeral director, page 2 should be detached.	Medical	Chook only	aminer: On the basis of exa								
E 3 E 3	ĕ	29b. Signature and title of certif		À		29c. Licens			29d. [Date signed (Mor	th, Day, Year)
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7	ſ	 Name and address of person Tasha Greenberg MI 				nn Street.	Baltimor	e, MD 21201			
Sta	ite	31. Date filed (Month, Day, Year	r) 32. Redistra		Ire .			, , , , , , , , , , , , , , , , , , , ,	-		
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State of Maryland / Department of Health and Mental Hygiene State Amend item#10d, perFh, G861,11/16/06 Tertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 12, 2006 8:20 P M Physician VLADIMIR PEREKALSKY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Director 216-27-2257 81 01/17/1925 UKRAINE Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner must be notified at MD N/A 1 √Yes 2 ¥ No BALTIMORE **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3615 FORDS LANE APT. 704 or items 23a 21215 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2□ No Specify Completed by 3 Widowed 4 □ Divorced 'naturei', Year or Dates: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Importent: If item 27 is marked other the eny injury or other traumatic event, the Aprice. 8 WELDER WELDING 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be NATHAN PEREKALSKY MANYA **GERB** 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12334 GREENSPRING AVENUE - OWINGS MILLS, MD 21117 BORIS PEREKALSKY / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/14/2006 OWINGS MILLS, MD HAR SINAI CONG. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed for use as the burial-transit 5 012 Due to (or as a consequence of): P.O. Box 68760, fhe attending physicien Black 6 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cete has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, TUDS 1 ☐ Yes 3 Probably 4 DUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed 2□ No 1□ Yes 20 1 Yes or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Certification: To 1 ☐ Yes 2 ☐ No 3 DOA ursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: investigation the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t To the Hospitel filled 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 254 Read 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens O. C.

		•	For State Registrar	State of Ma	arylanu / i	Cen	rimen tificat	e of D	eath	and w		glett Reg. N		3623	U
			Decedent's Name (First, Middle, Last	st)							2. Date of Dea	ath	ay Year	3. Time of Dea	th
	Physicia /Medic	_	Barbara		Ra	tnof	sky						1, 2006	8:47 A	М
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	er da itemb	une	11. Marital Status	12. Was Decedent I Armed Forces?		13. W	Yes, spec	dent of Hisp cify Cuban,	panic Or , Mexica	rigin? (Spe in, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Am Black, Whi		
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ō	문 = 교	ا: 1 ₀	27. Manner of Death	28a. Date of Inju (Month, Da		Time of		28c. Injury a	at		28d. Describe I		6 ☐Other (Speury occurred	eciry)	
Ö	nding ath. r: Afte	atio	1 Accident 5 Pending 2 Accident investigation		y rear)	Injury	М	Work? 1 □ Ye	es 2]No					
Division of Vital Records,	or Atterded	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Inj building, et	ury - At home, f c. (Specify)	arm, stre	et, factor	y, office			28f. Location (S City or Tox	Street a	and Number or Fi te)	lural Route Number,	
_	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer		(Check only 2 Medical Exar	nysician: To the best niner: On the basis of	examination a	ge, death	occurred estigation	at the time	e, date a	nd place, ath occurr	and due to the ed at the time.	cause((s) and manner a	s stated. e to the cause(s)	
	To the P within 24 To the P complete	Medical	29b. Signature and title of certifier	and manner sta	ited.			c. License					ate signed (Mon		
	or with		NWW O	V X	`		}								
	Q 1		30. Name and add s of person who	✓ let - cause of d	eath (Item 23a)	(Type 5	1	22949)			UCI	tober 31	, 2006	
_	D		Natasha	marcia				orget	own	Rd.,	Bethes	da,	MD 208	14	
	Sta Regist		31. Date filed (Month, Day, Year)	1 60 7	ar's Signature	The same of	colle i								

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Ratinofsky, Barbara, 10/3/106 08:47 am

		•	1 - State Registrar	State o	of Marylan		artment of t tificate of				ene g. Nd. 0 (16	362	31
	Physicia	an	1. Decedent's Name (First, Middle	, Last)					2.	Date of Death Month		Year	3. Time of E	Death
	/Medic		Jean Rode							ovember	12 20	006	12:1	0A ^M
	Examin	er	4a. Facility Name (If not institution 10053 Windstr				4b. City, Town, o		of Death		4c. County of	of Death Nard		
I	Funeral Director		5. Social Security Number 578–22–8850	6. Sex 1 □ M 2√2 F	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		Date of Birth (Month, Day, ct. 31,	Year) 1918	Coul	place (State or otry) Land	Foreign
	p ,		Usuat Residence of Decedent 10a, State 10b, County		100 0	N. Taura and a								
	Aaryla shov	20	Maryland Howa	ard	100. Cli	ty, Town or Lo Columb							Od. Inside City 1 ☐ Yes	
	28a-1	Directo	10e. Street and Number			- COLCUIA	10f. Zip Code			10	g. Citizen of W	hat Cou		
	deeth with the Maryland ims 23a or 28a-f show r must be notified at	io ie	10053 Windstre	eam Drive	Apt#3		21044	1			U.S.		,	
	ems ?	Funeral	11. Marital Status	12. Was Dec	edent Ever in U		Was Decedent of I	Hispanic Ori	igin? (Specify	y Yes or No-		- Americ	an Indian,	
9	be filed within 72 hours after deeth with the Marylan ital Hygiene. Id other than "natural, or items 23a or 28a-f show avent, the Medical Examination must be notified at	by Fu	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 ☐ Yes If Yes, Gi	2 2 No ve		1 ☐ Yes 2 🛣 No	Specify:	.,	, 5.5.,	Specify:			
215-0036	2 hour	ed t	15. Decedent	Year or E		16a. Deced	dent's Usual Occu	pation		1	6b. Kind of Bus	Wh:		
C[7	filed within 72 h Hygiene. other then "natu	Completed	(Specify only highes Elementary/Secondary (0-12)		1-4or 5+)	(Give	kind of work done DO NOT use retire	during mos	st of working				y	
7	ygien ygien t, Ite	Con		4	+	Music	Teacher				Baltimo		City	
Maryland	ntal H ad oth	Be	17. Father's Name (First, Middle, Edgar Hamilton		nt					First, Middle, M en Mill	aiden Sumame)		
2	s 1 end 2 should be f Heath and Mental item 27 is marked other treumatic ev	၉	19a. Informant's Name/Relationsh		110	19b. Mailir	ng Address (Street	<u> </u>				itate Zir	(Code)	
	nd 2 saith ar 27 is rr treu		Virginia Rodes	(Daught	er)		Rt. 108				Marylan			
e e	es 1 end 2 of Health filem 27 i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from		Place of Dispo cemetery, crer	sition (Name of natory or other pla		Date		0c. Location - 0			
Baltimore,	Pag tment tant: i		4 Donation 5 Other (S)		Me		ematory				tonsvil	le,	Maryla	nd
Ra	permit. Pages: Depertment of H important: if ite eny injury or ot once.		21. Signature of Funeral Service	Signature of Funeral Service Licensee WICZRE FUNERAL HOME 5555 Twin Knolls Ro Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or									21045	
			shock, or heart failure. List	complications that only one cause on	caused the deat each line.	th. Do not ent	er the mode of dy	ng, such as	cardiac or re	espiratory arre	st,		Approximate Interval Betw Onset and De	reen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aS	troke								Onsot and Di	Datii
ı	Examiner			Due to	(or as a consec	(uence of								
Ţ		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consec	quence of):								
	ecuted and -transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	/									
8760,	cate be executed physician and s the burial-transit	alE			(or as a conseq	(uence or):								
9		edicai		d										
ROX	death certifii e ettending p id for use as	an/M	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna		Ectopic pregnanc	v			23d. Date		*	
O. H	0 0 0	Physician/Me	in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nant at time of o		Other (specify)	,			Mon	th	Day Y€	ear
ב	The law requires that the deside hes been signed by the epage 2 should be deteched for	by Ph	Part II. Other significant condition	ns contributing to d	death but not res	sulting in the u	nderlying cause gr	ven in Part I.		23e. Did toba	acco use contri	oute to t	ne cause of de	ath?
Records,	w requires been sign should be		HTN, in	aict re	lated.	dem	utia,	COP	D	1 ☐ Yes	2 1 No	3 ☐ Prob	ably 4 Ur	nknown
ဝင္ပ	law request been 2 should	Completed	Seizere	do.						24a. Was an autopsy	24b. W	ere auto	psy findings av	vailable
<u> </u>		Con	Q	(perform	ed?	ath?	2□ No	230 0
Z E	ician: certific	Be	25. Was case referred to medical examiner?	Hospital:			0.1			check only one				
<u></u>	Phys r this ral dii	. To	1 ☐ Yes 2 € No 27. Manner of Death	28a. Date		ER/Outpatier	IL 3D DOX				nce 6 Othe		y)	
<u>o</u>	r Attending Phy ler death. irector: After thi by the funeral of	atior	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Moi	nth, Day Year)	Injury	Wo	rk?]Yes 2∐l		. 2000, 20 110	v injury cocurre	•		
Division of Vital	ai or Attendi s efter death. i Director: A d in by the fu	Certification:	3 Suicide 6 Could in determined	ined 200. Plac	e of Injury - At h ling, etc. (Speci	ome, farm, str fy)	eet, factory, office		28f	Location (Stre City or Town,	eet and Numbe State)	r or Rura	I Route Numb	·er,
_	tospita 4 hours Funere ely fille	edical C	29a. Certifier 1 Certifyin (Check only one)	g Physicien: To th Examiner: On the l and mai	e best of my kno basis of examina	owledge, death	n occurred at the ti vestigation, in my	me, date an opinion, dea	nd place, and ath occurred	due to the car at the time, da	use(s) and man te and place, a	ner as s	tated. the cause(s)	
	To the within 2. To the complet	₩	29b. Signature and title of certifie				29c. Licen	se number		29	d. Date signed	(Month,	Day, Year)	
}			Jano) (MD		Ds	,097	13	1	Vovem	sel	13,20	06
	8		30. Name and address of person JACEB CHERIAN	_	A 44	п 23а) (Туре,	Print)	71-	01.	1.	417	7 .	01 5	
	Sta	ate	31. Date filed (Month, Day, Year)	32.	egistrar's Signa	ature	اسر کار مرز ا	-310	مهالا	mora	10(1)	21	043	
	Registr		NOV 1 R	2006	Co.	K A	mark 1							

State of Maryland / Department of Health and Mental Hygier (a) Certificate of Death 3. Time of Death a 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Lou Sommers November 14, 8:00 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 32667 Johnson Road Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 06/01/1944 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F 216-42-7576 Maryland 62 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Wicomico Salsbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Items 23a 32667 Johnson Road 21804 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status illed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo White 7 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry rthan Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 12 should be filed w h and Mental Hygie 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dewitt T. Myers Mary C. Hamft 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun 32667 Johnson Road, Salsbury, Gerry R. Sommers
20a. Mathod of Disposition Maryland 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Brial 2 Cremation 3 Removal from State 4 □ Denation 5 □ Other (Specify) Crest Lawn Memorial | 11/17/2006 Marriottsville, MD 22. Name and Address of Facility Hubbard Funeral Home, Inc. S reduce of Paneral Service License 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Opset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition **Physician** mo resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the attending physicien and ned for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 2 No 1 Yes 2 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) D20507 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh arroll St Salisbury mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 Registrar 2006 DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and 1- State Registrar Certificate of Death	Mental Hygiene
1. Decedent's Name (First, Middle, Last) Physician Cossinger Ambien obtained to Classification	2. Date of Death Month Day Year NOVEMBER IS 2006 3. Time of Death 3. 20 A M
/Medical Corinne Antoinette Sterling Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	TOVATION TO ZOO
LORIEN @ RIVERSIDE BELCAM	
Funeral Director 5. Social Security Number 218–14–4975 6. Sex 1 M 2 F Representation of the security Number of Number of Number of Number of Number of Number of Number of Number of	(Month, Day, Year) Country)
Usual Residence of Decedent	Aug. 27, 1923 Maryland
10a. State 10b. County 10c. City, Town or Location Bel Air	10d. Inside City Limits 1 ☐ Yes 2 No
10a. State 10b. County 10c. City, Town or Location	10g. Citizen of What Country?
404 Cedar Spring Rd. 21015	USA
404 Cedar Spring Rd. 21015 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? Amed Forces? 13. Was Decedent of Hispanic Origin? (S. Amed Forces) 15. Very 30 No.	Specify Yes or No- rto Rican, etc.) 14. Race - American Indian, Black, White, etc.
1 Yes 2 X No Specify: Year or Dates:	Specify:
TO TO THE PROPERTY OF THE PROP	orking 16b. Kind of Business/Industry
Elementary/Secondary (0-12) College (1-4or 5+) Administrative Secreta 18. Mother's Name (First, Middle, Last)	Government Contractor
TO THE STATE NAME (First Middle Last)	ame (First, Middle, Maiden Sumame)
Bennett W. Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or River)	e A. Malone
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Relationship (Type, Print) 19b. Mailing Address (Street and Number or Relationship Rd.) 404 Cedar Spring Rd.	Rural Route Number, City or Town, State, Zip Code) ., Bel Air, Maryland 21015
Do Newhold of Disposition (Name of	Date 20c. Location - City or Town, State
1 Burial 2 Acremation 3 Removal from State 1 Donation 5 Other (Specify) 21. Signal prof Funda Service Linese McCanas Acrematory or other place) Hilltop Service Corp. 11-	-17-06 Towson, Maryland
	ome, P. A. ., Abingdon, Maryland 21009
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory arrest, Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition resulting in death) Medical Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final disease or condition resulting in death) Immediate (Final dis	Orași una seuli
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ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq ence of): C. Due to (or as a conseq ence of): Due to (or as a consequence of):	
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It FEMALE:	
A conficient of the part of th	23d. Date of delivery Month Day Year
O of the death of the state of	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Devantia, cerebrovarion as been significant of cerebrovarion of suppose significant of cerebro significant of cerebrovarion of suppose significant of cerebrovarion	24a. Was an 24b. Were autopsy findings available
The law required to the condition of the	autopsy performed? prior to completion of cause of death? 1 Yes 2 No
U 25. Was case referred to medical examiner?	eath (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing I	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
27. Manner of Death 1 No Natural 5 Pending (Month, Day Year) 28b. Time of Injury at Work? 2 Accident investigation 28c. Injury at Work? 1 Yes 2 No	200. Describe from injury occurred
The state of Decord of Dec	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Cause (Disease or injury that in initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury) Cause (Disease or injury) Cause (Disease or injury) Cause (Disease or injury) Cause (Disease or injury) Cause (Dis	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)
	29d. Date signed (Month, Day, Year)
D27975	11/15/06
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
State Registrar 31. Date filed (Month, Day, Year) NOV 1 6 2006 32. Registrar's Signature	8. Mn. 2/11/4

			For State Registrar	State of	Marylar	•			ealth a	and M	ental Hyg	giene 10g. No.	2000	362	234
	Physici	an	Decedent's Name (First, Middle, Last, Edward II. Colomo I to								2. Date of Dea Month 11/13	Day	Year	3. Time of I	
alt.	/Medic Examin		Edward H. Schmeltz 4a. Facility Name (If not institution, give		per)		4b. City,	Town, or	Location of	of Death	11/13	1	County of Dea		р.ш.
			Continuum Care					esvil				C	Carroll		
	Funeral Director		5. Social Security Number 6. Se 218-07-8394	x ZM 2□F	. Age (In yrs. 92	last birthday) Yrs.	Months Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day 12/16/	(, Year)		rthplace (State or country)	
	ט		Usual Residence of Decedent 10a. State 10b. County			ty, Town or Lo	ontion				12/10/			Maryland 10d. Inside Cit	
	Maryla f ehov	ō		1	100.01	Elders								1 🗆 Yes	•
	th the	Director	MD Carrol 10e. Street and Number			Erders	10f. Zip	Code				10g. Citi	zen of What C	country?	
	23a c		1825 E. Vincenza I	Orive				21784	1			US	SA		
	Reme	Funeral	11. Marital Status 1 ☐ Never Married 2☑ Married	12. Was Deced Armed Ford 1 Yes 2	es?	J.S. 13.	Was Dece f Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexican	gin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)		14. Race - Am Black, Wh		
930	within 72 hours after death with the Maryland ene. then "naturel", or Iteme 23e or 28e-f ehow he Medical Exercian munite notified at	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dat			1 🗆 Yes	2 X No	Specify:				Specify:	White	
Maryland 21215-0036	"natur	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	dent's Usu kind of wo	nk done d	during mos	t of workii	ng	16b. Ki	nd of Busines	s/Industry	
2	l withir liene. r then	omo	Elementary/Secondary (0-12)	College (1-4	for 5+)		ner	38 / 8(// 80	,			Serv	rice St	ation	
밀	al Hyg	Bec	17. Father's Name (First, Middle, Last)				IICI		18. Mothe	er's Name	(First, Middle,			401011	
<u>S</u>	d Ment d Ment narked natic e	P	John Frederick		z	405 14 7		(8)			nling	-	-		
ā Z	th and the notation that the notation the no		19a. Informant's Name/Relationship (T) Edward Schmeltz,				-				<i>i R</i> oute Numbe Sburg, I			Zip Code)	
ē,	of Heal	1	20a. Method of Disposition		1 .	Place of Dispo	sition (Na	me of	1		ate		cation - City o	r Town, State	
altimore,	Page ment cant: If ant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		ate	bwridge	•		1	1/17/	/06	E1	kridge		
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hyglene. Important: If Item 27 is marked other then "naturel", or Iteme 23a or 28e-f show emportant: In Item 27 is marked other then "naturel", or Iteme 23a or 28e-f show in July 9 or other traumatic event, the McJical Exaction must be notified at ODCs.		21. Signature of Funeral Service Incerio	2		Ga	ry L	. Kai		Fune	eral Ho				
			23a. Part 1. Enter the disease, or domp shock, or heart failure. List only o	lications that cau ne cause on eac	ch line.	th. Do not ent	er the mod	de of dyin	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Betw Onset and D	veen
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.			nch	VC.	Air	VCI	/ Di	20	Je	Onsor und D	- Call
	Examiner				r as a conse	quence or):									
7	uted 3 ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ras a consec	quence of):									
8760,	sate be executed only sicien and the burlat-transit	Ical Exa	resulting in death) Last	Due to (o	r as a consec	quence of):									
687	tificate g phys as the			d											4
P.O. Box 6	The law requires that the death certificate be executed tie hes been signed by the attending physicien and page 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2∏Feta ntattime of a	al death 3	Ectopic p Other (sp						23d. Date of de Month		'ear
	res that t signed by I be deter	ρ	Part II. Other significant conditions co	ntributing to dea	ith but not re	sulting in the u	nderlying o	ause give	en in Part I.				_	to the cause of de	
Sor	w requir been si should	leted									24a. Was	'es 2	,	Probably 4 U	
al Re	ysiclan: The lav is certificete hes director, page 2	Completed									autop perfor	sy med?	prior to death? 1 \(\text{Ye}	tutopsy findings a completion of ca s 2 No	use of
<u> </u>	siclan certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		TED/Outesties	nt 3□ DC	Othe	DE.		(Check only o				
on of	Attending Physiclan: or death. ector: After this certifice by the funeral director.	lon: To	27. Manner of Death 1. □ Natural 5 □ Pending	28a. Date of (Month)		28b. Time of Injury		28c. Injun Work	4 (25)	2	ne 5 Resid			ecify)	
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Płace o building	of Injury - At h g, etc. (Speci	nome, farm, str ify)			.03 20		28f. Location (S City or Tow			Rural Route Numb	er,
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	ro the vithin fo the comple	Mec	29b. Signature and title of certifier	and manne	or stated.		290	c. License	e number			29d. Dat	e signed (Mor	oth, Day, Year)	
	. 21-0)111					DI	137	25			11/14/		
	6		30. Name and address of person who c	tmood) 19	Rich	Print)	200	rd	We	stuni	nj	ter.	2115	7
	Sta Regista		31. Date filed (Month, Day, Year) NOV 1 6 28	1 10	gistrar's Sign	ature	34	-							

State of Maryland / Department of Health and Mental Hygien 20 0 6 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** WILSON November 15, 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor Baltimores
Vaar | If Under 24 Hrs. 8. Vursing Home aton Security Number yrs. iast birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 12M 20F Hours 247-58-2608 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Directo MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number MBROSE Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. OTHGRADE WORKER 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 Is marked oth eny injury or other traumatic event pone. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TEAN WILSON (DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -06 LANSDOWNE MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Pacility 2140 North Fulton Avenue 21217 Brown Ir. Funeral Home Baltimore MD JOSEPh Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumone da /Medical Due to (or as a consequence of): Examiner arlingm Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Fecords, P.O. Box 68760. by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ Ño 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1□ Yes EV Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TERRY Rel BALTO MAP HAMMONDS 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State NOV 1 6 2006 Registrar

			For State			d / Depa		lealth and N	lental Hy	211116	36236
			Registrar 1. Decedent's Name (First, Middle, L	ast)		061	tillcate of	Dealit	2. Date of De	110g. 110.	3. Time of Death
	Physicia		Mary Elizab	eth Walt	man				Novemb	Day Year er 14, 2006	
0	/Medic Examin		4a. Facility Name (If not institution, g				4b. City, Town, o	r Location of Death	1	4c. County of Dea	
			Harford Memor				Havre de			Harford	
5	Funeral		7.7.	Sex 7		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		thplace (State or Foreign ountry)
TAM	Director		198-07-2092 Usual Residence of Decedent		90			1	Jan. 2	9, 1916 Mar	yland
8	with the Maryland a or 28a-f ehow		10a. State 10b. County		10c. Ci	ty, Town or Lo	ecation				10d. Inside City Limits
7	the Maryla 28a-f ehor	ecto	Maryland Harfor	d	Fo	rest H					1 ☐ Yes 2 ☑ No
	with the or 2	Funeral Director	10e. Street and Number 301 Willrich Ci	rala tind			10f. Zip Code	1250		10g. Citizen of What C	ountry?
	deeth me 23	era	11. Marital Status	12. Was Dece	dent Ever in U	I.S. 13. \	21050- Was Decedent of H	-1352 fispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	USA 14. Race - Am	encan Indian,
9	ē # 5	F	1 Never Married 2 Married	Armed Ford	2 3N 0				Rican, etc.)		te, etc.
000	72 hours "naturel",	d by	3- Widowed 4 □ Divorced	Year or Da	tes:	,	1 ☐ Yes 🎎 No				hite
14/-06 21215-0036	within 72 hours after ene. then "naturel", or ite hedical Evanitie	Completed	15. Decedent's (Specify only highest of	Education rade completed)		16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	eation during most of work d)	king	16b. Kind of Business	/Industry
1/2 5	s withii lene. r then	d L	Elementary/Secondary (0-12)	College (1-	4or 5+)			n Dispatc		U.S. Gove	roment
		Bec	17. Father's Name (First, Middle, La	st)		TIGIN	por cacro			, Maiden Surname)	TIMETIC
Vlar	should be ind Menta i marked umatic ev	To E	Charles Alexand	er Crowl				Edith	(unk)	Erwin	
// // Maryland	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship							er, City or Town, State,	
			M. Elaine Watking 20a. Method of Disposition	ns Daugh		301 T	Willrich	Circle, I	Unit E,	Forest Hil 20c. Location - City of	1, MD 21050
h Baltimore,	eges int of t: If it y or o		1 ⊠Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Removal from S	Idle		sition (Name of matory or other place	1,	HS 3855775	-	
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2			23a. Part1. Enter the disease, or co shock, or heart failure. List on	monications that ca	used the deal	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
Ŏ	Physician		Immediate Cause (Final disease or condition				. Strok				Onset and Death
\sim	/Medical Examiner		resulting in death)	Due to (c	r as a consec	quence of):					
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7	nsit X ie	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0001010	. 40 4 50 1000	100.100 017.					
70	sicien and K	Еха	that initiated events resulting in death) Last	C. Due to (c	or as a consec	quence of):					
17 EV	ate be nysicie he bu	icai		d							
7 8	The law requires that the death certificate te has been signed by the ettending physoga 2 should be detached for use es the	ompleted by Physiclan/Medi	IF FEMALE:								
LAT.	ath co	lan/	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	al death 3	Ectopic pregnancy	N/A		23d. Date of de Month	livery Day Year
00	the de	ysic	1 ☐ Yes 2 ☑ 190 9 ☐ Unknown	9□ Unkno	unt at time of o	Jeatu 5∟	Other (specify)			N/A	
2 0	es that thighed by be detact	y Pr	Part II. Other significant conditions		ath but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
rds	w requires been sig should b	ed b	Cardiomyo	PAThy					10	Yes 2.☑No 3 ☐ P	robably 4 Unknown
Ual+man Division of Vital Records,	e law requ has been ja 2 should	piet	Sick Si	sus's	yndr	DIME			24a. Was		utopsy findings available
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of >	Attending Physicien: r death. ector: After this certification by the funeral director.	P.	1 ☐ Yes 2 ☐ No 27. Manner of Death			ER/Outpatien		4 Nursing no		dence 6 Other (Spe	ecify)
士日	th. : After funer	tion	1 Natural 5 Pending 2 Accident Investigat		f Injury n, Day Year)	Injury	Wor	k? NA Yes 2 □No	N/A		
ر isiv	Attendra dea ector	Certification;	3 Suicide 6 Could not	be 28e. Place	of Injury - At h	ome, farm, str	reet, factory, office		28f. Location (Street and Number or F	ural Route Number,
35	s afte	Cert	4 Hornicide	buildin	g, etc. (Speci		N/A		City or To		
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director; Air completely filled in by the fur	edical	29a. Certifier Certifying	aminer: (in the ha	SIS OF AYAMIN	ation and/or in	vectination in my o	mining death accur	red at the time	cause(s) and manner a date and place, and du	a ta tha anuna(a)
	ithin 2 o the	Mec	29b. Signature and title of certifier	and mann	er stated.		29c. Licens	e number		29d. Date signed (Mon	th. Dav. Year)
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	Ji		30. Name and address of person wh	o completed cause	of death (Ite	m 23a) (Type,	Print)	50-70		29d. Date signed (Mon 11-14. Z. Bel Alx MD	
2.0	1,			a, MD	500	OP)	per (he	sopenke	Dr-	AM	21014
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Re	igistrar's Sign	ature	nacht 2				
	negisti	ul .	NOV 1 6	2006	TERFER .	15' 13	879 SON				

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0	Physici /Medio Examin	al	Decedent's Name (First, Middle, La Wright Wiggins 4a. Facility Name (If not institution, given the second of	e street and number)	11				r Location of De	eath	ember		006 -	Time of Death
	Funeral Director		5 NG 105 p1 5. Social Security Number 6. S 216-62-2900 Usual Residence of Decedent		Θ (In yrs.	105 C last birthday) 54 Yrs.		er 1 Year	MOCC If Under 24 H Hours M	in. 8. Date of (Monti	of Birth h, <i>Day</i> , Yea 15/195		Birthplace Country)	(State or Foreign
	h the Maryland rr 28a-f ehow	Director	10a. State 10b. County		y, Town or Lo	Baltimore City					10d. Inside City Limits 1 ★Yes 2 No			
	hours efter deeth with the ture!', or items 23a or 28a al Examiner must be notif	Funeral Dire	10e. Street and Number 3023 Spaulding Ave				10f. Zip Code 21215 3. Was Decedent of Hispanic Origin? (Specify Yes or N f Yes, specify Cuban, Mexican, Puerto Rican, etc.)					10g. Citizen of What Country? USA No- 14. Race - American Indian, Black, White, etc.		
5-0036	72 hours efte natural', or it	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr.	1 Tes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No .	16a, Deced	1 ☐ Yes	2X No	Specify:				frican	American
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s, Wright Maryland 21	s 1 end 2 should be f Heelth and Mental fem 27 ie marked o	To B								Mag Rural Route N enue; Bal		y or Town, Sta		
Wiggins, l	permit. Pages 1 end 2: Department of Heelth ar Important: if Item 27 ie any injury or other trau		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Special	C	Mount Zion Cemetery 11/18/2006					20c. Location - City or Town, State Baltimore, Maryland			State	
Bal	permit. Depertrimporte any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Hon 638 N. Gilmor Street; Baltimore, MD 212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Ap	proximate erval Between
68760,		dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		o ne a consequa	uence of):		teru	1 dis	ease				set and Death
P.O. Box (at the death certificat by the ettending phy teched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	Ideath 3□	Ectopic (pecify)	′			23d. Date of Month	delivery Day	Year
cords, P	tw requires thet s been signed t s should be det	Completed by PI	Part II. Other significant conditions of the bacco	conditions contributing to death but not resulting in the					en in Part I.	-				
/ital Re	sician: The lav certificate hes irector, page 2	Be Com	25. Was case referred to medical exammer?							1 ☐ Y		deat	to comple h? Yes 200	
Division of Vital Records,	Attanding Physician: The law requires thet the death certifica (death. Getor: After this certificate hes been signed by the attending ph by the funeral director, page 2 should be deteched for use as the	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	yation M 1 Tyes 2 No								ute Number,		
á	Hospital or 24 hours afte Funeral Dir tely filled in i	Medical Cert	29a. Certifier 1 Certifying Pl	building, etc aysician: To the best of miner: On the basis of and manner sta	of my kno examina	wiedge, death	occurred vestigatio	at the tin	ne, date and pla pinion, death o	City o	the cause	(s) and manne	f as stated	
	To the vithin 2 comple	Me	29b. Signature and title of certifier	confipleted cause of d	(cv)	in D	•	D C	o number 0 162 Baltin	221		Date signed (M	1 28	Year) 2006
	Sta Registr		24350 Wes 7	Be Ved 32. Registra 2006	ese	AVEV	rve Conti	2	Baltin	rore	mD			

Tommy Woolridge 06-08608 UNK UNK

Please Type or Print in Black Indelible Ink

	State of Maryland / Depa 1-For State Cel Registrar	rtificate of Death		Reg. No. 2000	2522	
Physician/ ledical Examiner	Decedent's Name (First, Middle,Last)		2. Date of De		Time of Death . 0	
redical Examiner	Tommy Junior Woolridge 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or		er 12, 2006 4c. County of Death	0557 1115	
	1029 E. Baltimore Street	Baltimore			<u>-</u>	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday) If Under 1 Yea Months Day Yrs.	s Hours Min. 12	1	try) VΔ	
any	Usual Residence of Decedent 10a. State 10b. County 10c. City,	, Town or Location		1	0d Inside City Limits	
Aaryland 28a-f show 1 at once. ector	MD		ore City		1 X Yes 2 No	
th the Maryland 23a or 28a-f sho motified at once.	1029 East Baltimore Street	10f. Zip Code	21202	10g. Citizen of What Country? USA		
er death wi	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U Armed Forces? 1 Yes Give Year		spanic Origin? (Specify Yes or N n, Mexican, Puerto Rican, etc.) specify:	o- 14. Race - America White, etc. Specify: Africa		
72 hours aft n "natural" al Examine eted by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupa during most of working life	tion (Give kind of work done	16b. Kind of Business/Ind		
036 tthin 72 P ne. r than "r tedical E	Elementary/Secondary (0-12) College (1-4 or 5+)	unk	Do No. ado lomou,	unk		
5-0036 iled within 72 Hygiene. I other than the Medical	17. Father's Name (First, Middle, Last)		18.Mother's Name (First, Middle,			
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than marked other than 7 or 1 and 10 be Comple.	Louis Woolrideg 19a. Informant's Name/Relationship (Type, Print)	oolridge 19b Mailing Address (Street	Mary et and Number or Rural Route Nu	E. Bailey	(in Code)	
, MD 2121 and 2 should be fi eath and Mental iem 27 is marked traumatic event.	Michelle Woolridge / Daughter	2200 Linden A	venue; Baltimore,		p 0000)	
2	1 X Burial 2 Cremation 3 Removal from State Sac	Place of Disposition (Name of ce crematory or other place) Cred Heart Of J	esus Cem.	20c. Location - City or To	own, State	
Baltimo permit. Page Department of Important: injury or ott	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Name and Address	└─ 	Baltimore, Funeral Home, F	MD P.A.	
1.11	23a Part I. Enter the disease, or complications that caused the death	638 N. G	ilmor Street; Balt	imore, Maryland	21217 Approximate Interval	
Physician /Medical xaminer	failure. List only one cause on each line.	cardiovascular di		iost, shoot, of field	Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	ν ε).				
miner	cause. Enter Underlying Cause (Disease or injury that initiated					
nd nd ransit	events resulting in death) Last Due to (or as a consequence of					
60, ate be execu hysician and e burial - tra	X unpended X amended #8,23a,2	per fh g864 2- 27, perFh, ME, g862	28-0/ vt , 12/5/06 TT			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hour after death To the Funeral Director After this certificate has been signed by the attending physician and completely fill, d in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification; To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the pregnant in the past 12 months?	prancy 2 Fetal death 3		23d. Date of delivery Month Da	y Year	
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ords, F w requires us been sign should be					psy findings available	
Records, The law require ficate has been sig. page 2 should bb Completed			auto perf 1 ✓ Yes	ormed? death?	npletion of cause of	
tal Rection: The certificate ector, page	25 Was case referred to medical		e of Death (Check only one)	2 No 1 Yes	2 110	
f Vital Physician: er this certif ral director. To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 27 Manner of Death 28a. Date of Injury			Residence 6 Other: S	Scene	
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Division C To the Hospital or Attending within 24 hour after death To the Funeral Director Ah completely fill d in by the fun	Suicide Could not be	nome, farm, street, factory, office I	ouilding, etc. 28f. Location or Town,	(Street and Number or Rura State)	Route Number. City	
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To the Hos within 24 h To the Fur completely	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated	•		• •		
¥ , F ° N	29b, Signatule and title of certifier	29c Licens O.C.		29d. Date signed (Month		
(h)	30. Name and address of person who completed rause of death (Iten		IVI. be-	November 12, 200		
(3)	Susan Hogan MD. Assistant Medical Examine	r 111 Penn Street, Bal	timpre, MD 21201			
State Registrar	31. Date filed (Month, Day, Year) NOV 1 5 2006 32. Rejstrar's Signat	ure & Asset				

			1 - For State Registrar	State of	Marylan	id / Depa <i>Cei</i>	artment of F	lealth and N Death		giene	006	362	39
			Decedent's Name (First, Middle, La	st)					2. Date of De	ath		3. Time o	of Death
	Physici		Clarice Antir	1					Month October	Day 26	Year 2006	9:30	р м
	/Medio Examin		4a. Facility Name (If not institution, giv		nber)		4b. City, Town, o	or Location of Death		•	ounty of Death	1 3.30	P
			Mariner Health	of Bethe	sda		Bethes	da		N	Iontgom	ery	
	Funeral		Social Security Number 6. S		7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da April	th	9. Birth	place (State	or Foreign
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	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					t0d. Inside C	ity Limite
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	Jeath ma 23	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.			ecify Yes or No		ited St		
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93	ai', o	by	3 ☐ Widowed 4 💆 Divorced	If Yes, Give Year or Da	e ites:		1 ☐ Yes 2 🖺 No	Specify:		S	pecify: Whi	te	
5-0	be filed within 72 hours after death with the Maryland ital Hygiene. I have nother than "natural", or itema 23a or 28a-1 show event, the Medical Evertiner must be notilied at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Dece	dent's Usual Occup	pation during most of work	rina	16b. Kind	of Business/In	dustry	
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and	be fi	Be	17. Father's Name (First, Middle, Last					18. Mother's Nam		Maiden Si	umame)		
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ĬĢ.	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special		State	æmetery, crer	natory or other plac	· I	1/2006				
Baltimore, Maryland 21215-0036	~ ~ ~		21. Signature of Funeral Service Lice		FL.	22	LII Cremat 2. Name and Addre	tory 11/01	1/2006	bren	twood,	Maryla	ind
<i>y</i> 88	permit. Depart Import any inj		DW A (S:	imple Tri 040 Rocky	ss of Facility Lbute Fune 7ille Pike	eral and	d Crem	nation (Center	1852
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	/Medical		resulting in death)	u	or as a conseq		56						
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	ש ב	Iner	cause. Enter Underlying	Due to (d	or as a cunsac	uence of):							
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B	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live bi	nth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pregnancy Other (specify)	У		230	d. Date of delive Month	-	Year
o.	that the de ned by the a detached t	ysle	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□ Unkno		04.11							
σ.	that	y Pt	Part II. Other significant conditions of	ontributing to de	ath but not res	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	obacco use	contribute to the	ne cause of o	death?
rds	quires n sign	d b	History of brea	st canc	er				1 🗆 🗅	Yes 2.2∰	No 3 ☐ Prob	ably 4 🔲	Unknown
· 2 8	w requir s been si should	lete							24a. Was	an :	24b. Were auto	psy findings	available
Antic tal Reco	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Completed by Physician/M								rmed?	24b. Were auto prior to co death?		ause of
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ر ح	ysici is cer direc	To B	examiner? 1 □ Yes 2🏋 No	Hospital: 1 ☐ In	patient 2 🗆	ER/Outpatien	t 3 DOA Oth				Other (Specif	v)	
aR/CE sion of V	Attending Physician: r death. sctor; Atter this certifics by the funeral director.		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date o	f Injury n, Day Year)	28b. Time of Injury	28c. Injur Wor	v at	28d. Describe I			,,	
Sio	Nttendia death. ctor: Ai y the fu	atle	2 Accident investigation					Yes 2 □ No					
CLARICE ANTIODIVISION OF VITAI Records, P.O. Box	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place	of Injury - At ho g, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S City or Tox		Number or Rura	l Route Num	ber,
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_	To the within 2 To the comple	Me	29b. Signature and title of certifier	and main	or stated.		29c. Licens	e number		29d. Date s	signed (Month,	Day, Year)	
	F ≤ F ŏ		· LX	Mode	4,		D53	691			7/2006		
	14:		30. Name and address of person who	completed cause	of death (Item	1 23a) (Type				10/2	7 / 2000		_
								Bethesda,	Marvla	nd 20	817		
	Sta	te	31. Date filed (Month, Day, Year)	32 Re	gistrar's Signa	ture	uli		iidi yid	4 40	<u> </u>		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2006 Constance L. Arthur Ontobes 25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bathinase Washington medical Centre Burn Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Dec 10 6. Sex 7. Age (In vrs. last birthday **Funeral** Birthplace (State or Foreign Country) Days Hours Months Min ^{Year)} 1920 1 ☐ M 2 ▼ F 85 Yrs. Maryland Director 219-05-1053 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Anne Arundel Annapolis Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1915 Vincent St. 21401 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3€Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Elementary/Secondary (0-12) College (1-4or 5+) Public School 12th Teacher Assistant <u>lyr</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Baden Hattie Reid ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas E. Arthur(Son) 98 Dewey Dr. Annapolis, Md. 21401 20b. Place of Disposition (Name of Hemately organizates) or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 10-30-06 Annapolis, Md. Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Licensee Wm. Reese of & Sons Mortuary, P.A. B. Beese MOOS83 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VManon repre /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical asn IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has l autopsy perform certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) **¾** № Inpatient 2 1 TYes 2 ER/Outpatient 3□ DOA ihis 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: Injury Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Fo the ...
within 24 hours
*** the Funeral Director of the funeral Director of the funeral Director of the funeral pixers of the fun 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25 2006 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

1 2006

NOV 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2006 Mildred November 6, 5:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 0akland 445 Oakland Drive Garrett If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 ☐ F Director Nov. 6, 1918 | West Virginia 234-54-1633 88 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28s-1 show any injury or other traumatic event, the Medical Exercises. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Clarksburg Harrison 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rt. 3 Box 103 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married ¹X☐ Yes 2☐ No Specify: Specify þ 3 Widowed 4 Divorced White Spain Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beautician Cosmtology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alvarez Gonzalez Manuel Maria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 N. 4th Street, Oakland, MD 21550 Donna Alvarez 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Bridgeport Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 11/8/06 Bridgeport, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burdock-Durst Funeral Home Katherine Sweether 21 N. Second St., Oakland, MB 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Renal Cell Cancer 6 months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and the character as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown High Blood Pressure 1 Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? neral Director: After this certificate has filled in by the funeral director, page 2.4 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 25 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson, 311 N. 4th Street, Oakland, MD 31. Date filed (Month, Day, Year) 32. Ramstrar's Signature State Registrar NOV - 6 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36242 State of Maryland / Department of Health and Mental Hygiene [] [] 6 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Octos Year 3127 AM 2206 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince (reurge MINICE Me (In yrs. last birthday) 9. Birthplace (State or Foreign (A12-1/4 C 5. Social Security Number 1 Year Days 12 M 2□F Months 69 217-36-9319 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No MAILYLAND)hite 10g. Citizen of What Country? 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 206 95

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA Windson 4072 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Duperison 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mª Nes

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Director

Be Completed by Funeral

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23s or 28s-f show eny Injury or other traumatic event, if a Medical Examination must be notified at once.

within 24 hours after death. To the Funarel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (St	reet and Number or R	lural Route Number, City or Town, Stat	te, Zip Code)
Varrence Adam	4 / Sun	4072 Win	door Hekh	to Pl White Pla	las MI)
20a. Method of Disposition	20b.	Place of Disposition (Name of	of .	Date 20c. Location - City	or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐	Tueurovar irom State	cemetery, crematory or other	C Prace)	1. 1	MID
4 □ Donation 5 □ Other (Special	• •	111111111	Cen Illi	1) b Daden	- 1/
21. Signature of Juneral Savice Lice	900	22. Name and A	ddress of Facility	120605 Aguasca	Kvad
of sunt	54 1	91 Adams	Finest 1.	time PA Aguasci	M1) 2060
23a. Part1. Enter the disease, or com shock, or heartfailure. List only	plica n that caused the dea	th. Do not enter the mode of	dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
Immediate Cause (Final	2	ic Shock			Onset and Death
disease or condition resulting in death)	aDue to (or as a conse				
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Sequentially list conditions,	THE RESIDENCE AND ADDRESS OF THE PARTY OF TH	iratory Fai.	Lure		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse				
Cause (Disease or injury that initiated events	End S	Stage Renal	Disease		
resulting in death) Last	Due to (or as a conse-	quence of):			
	d				
IF FEMALE:	23c. If yes, outcome of pregn	ancv		and Date of	4-6
23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fet	al death 3 Ectopic pregn		23d. Date of Month	Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5 Other (specif	y)		,
					
Part II. Other significant conditions	contributing to death but not re	sulting in the underlying caus	e given in Part I.	23e. Did tobacco use contribut	te to the cause of death?
				1 ☐ Yes 2 ☐ No 3 ☐	Probably 4 Unknown
				24a. Was an 24b. Were	e autopsy findings available
					to completion of cause of
				1 Yes 2 No 1 □	
25. Was case referred to medical examiner?				ath (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other: 4 Nursing I	Home 5 Residence 6 □Other (5	Specify)
27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c.	Injury at Work?	28d. Describe how injury occurred	
1 Natural 5 Pending 2 Accident investigatio		M	1 ☐ Yes 2 ☐ No		
3 ☐ Suicide 6 ☐ Could not b	289. Place of injury - At r	nome, farm, street, factory, of	fice	28f. Location (Street and Number o.	r Rural Route Number
4 Homicide	building, etc. (Spec	(y)		City or Town, State)	
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(Check only 2 Medical Exa	miner: On the basis of examin	ation and/of investigation, in	ne time, date and place my opinion, death occ	e, and due to the eauss(s) and main our urred at the time, date and place, and	t as stated. due to the cause(s)
Oney	and manner stated.				
29b. Signature and title of certifier	1.1	29c. Li	cense number	29d. Date signed (M	lonth, Day, Year)
MALL	Mr.	1	127677	111/251	106
30. Name and address of person who	mpleted suse of death (Ite	m 23a) (Type, Print)	213 11	10/01/	
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Optine	MALL 64 64 6	לבון וחחל אי	0:17 1/1	chevery 'lly	20103

State

Registrar

31. Date filed (Month, Day, Year)

OCT 3 0 200\$

Please Type or Print in Black Indelible Ink Nancy Avery State of Maryland / Department of Health and Mental Hygiene 2006 35243 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day November 4, 2006 **Medical Examiner** Nancy Lee Avery 1231 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Prince George's Laurel Regional Hospital Laurei 8 Date of Birth(MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** 7 Age (In vrs. last birthday) oreign Months Davs Hours Min Director Country) M 2 X F 244-84-3684 12/27/50 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygine.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic vent, the Medical Examiner must be notified at once Prince Georges Beltsville Director 10g. Citizen of What Country? 41344 Cherry Hill Road, Apt. 303 20705 United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black Armed Forces? White etc 1 X Never Married Yes 2 X No If Yes. Give Year 1 Yes 2 X No specify Widowed Divorced Specify: Black ۾ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 2 Certified Nursing Assistant Medical 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Charles Avery Mary Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20705 19a. Informant's Name/Relationship (Type, Print) Edith Waterspratt/Sister 41344 Cherry Hill Road, Apt. 303, Beltsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Donation 5 Other Specify John Church Cemet 11-11-06 Wilson's Mills, NC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Strickland Funeral Services, P.A 6500 Allentown Road, Camp Springs, MD 20748 an 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical X UNPENDED AMENDED attending physician or use as the burial #23a,PII,27,28a-f, perME, g862, 12/14/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If ves, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Multiple injuries, diabetes mellitus; end stage kidney disease; 24a Was an 24b. Were autopsy findings available seizure disorder; sarcodosis autopsy prior to completion of cause of performed death? 1 🗸 Yes Yes 2 25. Was case referred to medica 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be examiner? 1 / Inpatient DOA this 2 ER/Outpatient 3 Nursing Home 5 Residence 6 2 1 🗸 Yes 2 28d Describe how injury occurred Subject fell from wheelchair during 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c Injury at Work? Certification: Natural 5 Pending Yes 2 X No To the Funeral Director: 10/30/2006 11:28 am sud<u>den stop in transport van</u> 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Rt. 29/Briggs Chaney Rds. Montgomery County, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide determined (Specify) Street Homicide 2 Certified Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical ✓ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 5, 2006 d address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

31. Date filed (Month, Day, Year NOV 0 8 2006 32. Registrar's Signature

Registrar

06-08488 Robert Angeletti

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State of Maryland / Department of Health and Mental Hygiene

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72 hours after death with the Maryland "natural", or items 23a or 28a-f she al Examiner must be notified at once forced by Europeal Director	<u> </u>	Marital Status Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2	ver in U.S.	13. Was D If Yes,	ecedent of Hispanic Orig specify Cuban, Mexican	gin? (Specify Yes o , Puerto Rican, etc.)	r No- 14. Race White	e - America e, etc.	an Indian, Black,
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Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene Important: If iten 27 is marked other than "natural", injury or other trannatic event, the Medical Examiner TO DO Compiled Aug	ğ	12	College (1-4 or 5-	*)	Compu	ter Technic		Comp		
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Baltimo permit. Page Department of Important: injury or ott	21.	. Signature of Funeral Service Licen	see ,	1	22. Nam Hick	e and Address of Facility S Home for				
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Ox 687 eath certifi attending for use as t	1 S	past 12 months? Yes 2 No 9 Unknown	4 Pregnant at t	ime of death		(Specify)		8		,
J. Box the death c by the atten sched for us	Physician Pa	art II. Other significant conditions	9 Ouknown	but not recul	ilting in the und	ortuing cours given in Bo	od I 23a F	id tobacco use contr	ihiita ta th	o pouce of deeth?
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To the Hos within 24 h To the Fun completely	Medical 29					, in my opinion, death oc				
	29	b. Signature and title of certifier	and manner stated			29c License number		29d Date sign	ed (Monti	h, Day, Year)
		anes 2				O.C.M.E.		November	8, 2006	5
	30). Name and address of person who		,	*	. D. W.	04004			
	0.4	Data filed (Marth, Day Year)	nt Medical Exam			eet, Baltimore, MD	21201			
Sta Registr	_	Date filed (Month Day, Year) 2	32. Registrar		STORY OF	A Part of the Part				

State of Maryland / Department of Health and Mental Hygien 0 0 6 36245 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** MURIEL ANNETTE BENJAMIN OCTOBER 26, 2006 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 🔯 F Hours Yrs. Director 126-14-3099 86 SEPTEMBER 2, 1920 NEW YORK Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Madical Exercines must be notified at 1 ☐ Yes 2 🕅 No Director MARYLAND MONTGOMERY ROCKVILLE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23e 6105 MONTROSE ROAD 20852 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: þ Specify. 3 XWidowed 4 ☐ Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) as 1 and 2 should be fit of Health and Mental H Item 27 is marked of MAX DRUSIN ျှ LILIAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JEFFREY A. BENJAMIN/SON 7223 WILLIOW OAK PLACE, SPRINGFIELD, VIRGINIA 22153 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If Ite
any injury or ott 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CREMATORY 11/02/2006 BRENTWOOD, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-transit and Due to (or as a consequence of): attending physician I for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of refities 29d. Date signed (Month, Day, Year) D 35436 30. Name and address of person who completed cause of death (Item 23a) (Type_Print) 6121 HOW TROSERD, PECKVILLE MD ZOSGZ 31. Date filed (Month, Day, Year) State 2006 Registrar

Exa	miner	
lospitel or Attanding Physicien: The law requires that the death certificate be executed	runded Director. After this certificate has been signed by the attending physician and signed in by the funeral director, page 2 should be detached for use as the burial-transit.	

	State Registrar 1. Decedent's Name (First, Middle, La	ist)				of Dea		2. Date of De.	Reg. No. ath			3. Time of Death
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	3813 ST. BARNABAS	ROAD #20)3		SUIT				PI	RINCE	GEO	RGES
		Sex 7. 1 M 2 □ F		last birthday) 4 Yrs.	If Under 1 Months	Year If Un Days Hou	der 24 Hrs. Irs Min.	8. Date of Bird (Month, Da JUNE 0	v. Year)		Country	Ce (State or Fore
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Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What C										Country	?
5	3813 ST. BARNABAS ROAD #203 20746 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin							ecify Ves or No		ITED S		
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	ALBERT BECKHAM				BRANNU	-						
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111-	KATHY L. BECKHAM 20a. Method of Disposition	/ WIFE	20b.	Place of Dispo	ST. BA	of		FZU3 SI		AND, Mocation - City		
	XXBurial 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Special Control C		ale	cemetery, cre			10/	31/2006				
	21. Signature of Funeral Service Lice		PIAT					AL HOME		HELTEN MARVI A		
	1. 4. M/c	uslll	_				ND RO			ND, ME		
	23a. Part1 Enter the disease, or con shock, ir heart failure. List only	nplications that cau	sed the dea th line.	th. Do not en	ter the mode of	of dying, sucl	n as cardiac	or respiratory a	rest,		_ In	pproximate iterval Between
	Immediate Cause (Final disease or condition		AC ARE								0	inset and Death
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m m	Sequentially list conditions, if any, leading to introducted cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): PEREPHERAL VASCULAR DISEASE											
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Med	IF FEMALE:						-		-		_	
Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XXto 9 Unknown		h 2 ☐ Fet nt at time of	al death 3	Ectopic preg				23d. Date of delivery Month Day Year		ay Year	
	Part II. Other significant conditions	contributing to dea	th but not re	sulting in the u	inderlying cau	se given in P	art I.	23e. Did t	obacco u	se contribut	e to the	cause of death?
ed by	STROKE, DEPRESSI	ON, PROS	CATE C	ANCER	HISTORY	YIN		1 🗆 `	es X	No 3□	Probab	ly 4 □Unknov
Completed	REMISSION							24a. Was		24b. Were	autopsy	y findings availat
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Be	25. Was case referred to medical examiner?					26. F	lace of Deat	h (Check only o				
2	XXYes 2 □ No	Hospital: 1 □ Inj		ER/Outpatie			Nursing Ho	me XX Resid			specify)	
27. Manner of Death 1 XXI stural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work? 1 Yes 2 No								now injur	w injury occurred			
Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street a City or Town, Sta								Street and vn, State,	d Number or	Rural R	loute Number,
edical	29a. Certifier XX Certifying P (Check only one) 2 ☐ Medicel Exa	hysicien: To the baseminer: On the basemand manner	is of examin	nowledge, deat nation and/or in	h occurred at vestigation, in	the time, dat my opinion,	e and place, death occur	and due to the red at the time,	cause(s) date and	and manner place, and	as state due to th	ed. le cause(s)
∑	29b. Signature and title of certifier	/			29c. t.	icense numl	oer		29d. Date	signed (M	onth, Da	y, Year)
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State of Maryland / Department of Health and Mental Hygiene 006 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death **Physician** October 25, 2006 Isaac Brown 3:02 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1931 9. Birthplace (State or Foreign Months | Days | Hours | Min. (Month, Day, Year) 1931 9. Birthplace (State or Foreign Months | Days | Hours | Min. (Month, Day, Year) 1931 9. Birthplace (State or Foreign Months | Days | Hours | Min. (Month, Day, Year) 1931 9. Birthplace (State or Foreign Months | Days | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hou 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 1 XM 2 □ F 75 216-78-1083 Director September 1, Victoria, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iteme 23a 6711 Northwest Drive; Apt. H-2 20782 Jamaica, West Indies death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: **Black** Specify: 3 ☐ Widowed 4 ☐ Divorced 'naturei' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Geographic Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Janitor Society 7th grade permit. Pages 1 and 2 should be like Department of Health and Mental Hy important: if Item 27 ie marked other any injury or other traumation. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Brown Mercella Mitchell 19a. Informant's Name/Relationship (Type, Print) Eva Thompson Brown (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Uzzeal Alexander Brown (Son) 2473 Vineyard Lane; Crofton, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Nov.11,2006 4 ☐ Donation _ 5 ☐ Other (Specify) George Washington Cemetery Adelphi, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician u lace ar an an /Medical Due to (or as a conseguence of) Examiner ysu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): ed by the attending physician detached for use es the buria Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown ete has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificete 1□ Yes 2 No 2**X** No 1 Yes Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident i or Attended of the death Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours 1 X Centrying thysicien: To the best stony knowledge death occurred at the time, date and place, and one to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 0-25-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen M. Smith, M.D.; 7600 Carroll Avenue; Takoma Park, Maryland 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 31 2006 Registrar

. •		1 - State RegistraAmended # 3	State of M gc, per pl	aryland/De I1/2/06 Ty,	partment ertificate	of H	ealth and Death	d Mental Hyg	giene Reg. No.	2005	36248
Physicia /Medic	_	Decedent's Name (First, Middle, Last) John Brown						2. Date of Dea Month October	Day	2006 Year	3. Time of Deathpr 8:40 AM
Examin Funeral	er	4a. Facility Name (If not institution, give s Doctor s Communi 5. Social Security Number 6. Sex 1K	ty Hospi	tal ge (In yrs. last birthd	Lanha	am	If Under 24 H	Irs. 8. Date of Birt in. (Month, Da	Pr	Cou	orge's place (State or Foreign
Director Move Move	5	247-20-1132 Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location			Novembe	r 7,	1922 S.	. C . 10d. Inside City Limits 13∑ Yes 2 □ No
2 should be filed within 72 hours after deeth with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f ehow eumatic event, the Medical Exarch at must be notified at	eral Director	MD Prince G 10e. Street and Number 12220 Kings Arro 11. Marital Status	w St.	Mitchel	10f. Zip 0	0721			10g. Citizen of What Country? U.S.A.		
hours after disturbly, or item	ed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Armed Forces? If 1 ☐ Yes 2 No If Yes, Give 1 Year or Dates:			Vas Decedent of Hispanic Origin? (Specify Yes or I Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 25 No Specify: ent's Usual Occupation			14. Race - Ameri Black, White, Specify: B1a	etc. ack
i Hygi other	Be Completed	(Specify only highest grade Elementary/Secondary (0-12) 6 17. Father's Name (First, Middle, Last)	ive kind of work e. DO NOT use DETVISON	done d retired)	uring most of v	working Name (First, Middle,	16b. Kind of Business/Industry Env. Svcs.				
d 2 should be th and Mental 17 is marked o treumatic eve	ToB	John Brown, Sr. Matilda Nelson 19a. Informant's Name/Relationship (Type, Print) Cassandra McIntyre - Daughter 12220 Kings Arrow St., Mitchel									•
permit. Pages 1 and 2 should be Deperment of Heelth and Manta Important: If Item 27 is marked any Injury or other treumatic ev		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Di	sposition (Name crematory or oth coln Ce	of er place M •	11/	2/2006	20c. Lo Brer	cation - City or To	own, State
Dependent Dependent Important Import		21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that cause	d the death. Do not	3401 B1	adeı	nsburg	t. Lincol Rd. Brent	wood		722 Approximate
death certificate be executed (Medical Example 1	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	brovascu1 a consequence of): a consequence of): a consequence of):	ar bise						
thet the death certific ed by the ettending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 ☐ Fetal death	3 □Ectopic pred 5 □ Other (spec				2	23d. Date of delive Month	ery Day Year
rw requires thet the s been signed by th i should be detache	ted by PI	Pan II. Other significant conditions con Hypertension	tributing to death b	out not resulting in th	e underlying cau	ise give	n in Part I.		id tobacco use contribute to the cause of death?		
The law ete has b page 2 sl	e Completed by	25 Was case referred to medical					26 Place of D		sy med? 2 🔯 No	prior to co death?	opsy findings available impletion of cause of
ding Phys h. Atter this funeral di	ation; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 X Inpati 28a. Date of Inju (Month, Da		Other: 4 Nursing He 28c. Injury at Work?			ath (Check only one) Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
To the Hospital or Attenwithin 24 hours effer death To the Funeral Director:	al Certification;	3 Suicide 4 Homicide 29a. Certifier 1 Certifying Physics	street, factory,	the time	e, date and pla	City or Tow	n, State)				
To the Howithin 24 h	Medical	29b. Signature and title of cerifier	ner: On the basis of and manner st	of examination and/o	29c.	n my op License	number 58290	curred at the time, o	date and 29d. Date	place, and due to signed (Month, 30/2006	o the cause(s)
Sta	te	30. Name and address of person who co S.Mutta 31. Date filed (Month, Day, Year) OCT 31 2006	, MD	death (Item 23a) (Ty	4203 Q	ueer	nbury R	oad Hyat	tsvi	11e, MD	20784

State of Maryland / Department of Health and Mental Hygien U U 6 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Norma Stanton BACHTELL Oct. 24, 2006 4:45 p. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 905 Queen Anne Court Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕅 E 88 Yrs 213-68-7022 Sept. 28,1918 Director Rhode Island Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Items 23a 905 Queen Anne Court 21740 USA Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 X No white Specify: Completed by 3 Widowed 4 □ Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Other then Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Peges 1 end 2 should be fit trent of Heelth and Mental H tent: If Item 27 is marked off jury or other traumatic even George Edward Merkle Annie Stanton Potter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Kennedy - daughter 558 Ontario Dr., Ontario, New York 14519 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department of Important: If any injury or ones. Hagerstown Crematory 10/25/06 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a Part1 Enter the disease Immediate Cause (Final disease or condition **Physician** MYOCARDIA resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ue to (r as a consequence of or Attending Physician: The law requires that the death certificate be executed use es the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the ettending physiclen P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccourse contribute to the cause of death? Division of Vital Records, Completed by page 2 should be 2 🗆 No 3 Probably 4 Unknown peed Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate hes autopsy performed 1 Yes 2 No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Sidence 6 Other (Specify) Medical Certification: To 1 Yes/ 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No death. the f 2 Accident within 24 hours efter deat. To the Funeral Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 15 death (Item 23a) (Type, Print) ROBERT Day. 32. Registrar's Signature

State Registrar

3

State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Margaret Elizabeth Buckler 28, 2006 October 0 8:35 p.m. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown
If Under 1 Year | If Under 24 Hrs. St. Mary's 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 XF Yrs Director 579-34-0430 May 14, 1929 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location rel', or itema 23a or 28a-f ehow Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29754 Allen Road 20659 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Waitress Restaurant permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Clyde W. Wood Pearl E. Penn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Buckler / Son 39935 Holly Bank Drive, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 11-2-2006 Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home M01206 Kyle S. Simons 30195 Three Notch Rd., Mechanicsville, MD 20659 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** fa11402 Hypoxic orspioately HOUS /Medical Due to (or as a consequence of): Examiner 17945. congestive negit ta1/482 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examine 7945 The law requires that the death certificate be executed Anoxic Encephalo Due to (or as a consequence of): 7975 Records, P.O. Box 68760. Scirules Completed by Physician/Medical ţ, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Obstowence 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has t irector, page 2 s 1 ☐ Yes Division of Vital 2 No or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3□ DOA this. After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 -Natural death. 1 ☐ Yes 2 ☐ No d in by the 2 Accident 3 🗍 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dhanajay Bhavsar, M.D..24035 Three Notch Road, Hollywood, Maryland 20636

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 3 1 2006

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Helen Theresa Borne 4:54 C 2006 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/20/1922 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 84 044-14-7490 Yrs Director CTUsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. Sther than "natural", or iteme 23a or 28e-f ehow ent, the Madical Examinar must be notified at Director PA Franklin Greencastle 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17225 551 N. Washington Street US death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Completed by Specify 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Registered Nurse Hospital of the state of th permit. Peges 1 and 2 should be file Depertment of Heelth and Mental Hy Important: If Item 27 is marked oth eny jury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Peter Ivaniski Emily (nmn) Sienkiewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19829 Reidtown Road, Hagerstown, MD 21742 JoAnn B. Crowley / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/31/2006 Rose Hill Cemetery Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) 515 RP **Physician** /Medical Due to (or as a consequence of): Infarction Examiner o cardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit nde carditis been signed by the attending physicien and should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Denknown 24b. Were autopsy findings available pnor to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☐ No iours after death.
neral Director: After this this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel c within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 opal MURSHED ARID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Michael Beach, Jr. 2006 10:10 a.m. Charles November 4, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Mechanicsville <u>29764 Allen Road</u> If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1XM 2□ F 40 Director 214-98-2127 Oct. 22, 1966 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hyglene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show unt; of hehe traumafte event, the Medical Examiner must be notified at ury or other traumafte event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Director St. Mary's Mechanicsville Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20659 29764 Allen Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Print Operator Merkle Inc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Michael Beach, Sr. P Judith Ann Edsall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau Candy Kitts / Spouse 29764 Allen Road, Mechanicsville, Maryland 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Cr. 11/8/2006 | Charlotte Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. Edun. P.O. Box 128, Charlotte Hall, Maryland 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastanc CHROSEN Primary adeno caranoma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsugarance of Examine Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/200

State

Nikkal Uppal, M.D.,

NOV 08

2006

31. Date filed (Month, Day, Year)

24035 Three Notch Road, Hollywood, MD 20636

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar		Certifica	ate of	Death				Reg. No	20	100) 3523
Physician Medical Examine		, ,			·			Date of De Month Novemb		Yea 006		3. Time of Death 1505 hrs
	4a. Facility Name (if not institution Saint Mary's Hospital			41	c. City, Town, o			-	4	c. County o		
Funeral	5. Social Security Number		e (In yrs. last birt	hday)	If Under 1 Ye		er 24Hrs.	8. Date of I	- 1		9 Birth	nplace (State or
Director	215-78-5879	1X M 2 F	44	Yrs.	Months Da	ays Hours	Min.	June	3, 1	962	Foreigr Cou	ntryMary1and
any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locatio	n							10d. Inside City Limits
* .	Maryland St. N	Mary's	Lexin									1 Yes 2 X No
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once,	10e. Street and Number 21060 Hermanvi	ille Road		I	10f. Zip Code 206		_		_	izen of Wh		,
h with the ems 23a o	11. Marital Status	12. Was Decedent I	Ever in II S	13 Was	Decedent of H		nin? / Snor	rify Voc or N		ited		an Indian, Black,
or death	1 X Never Married 2 M	arried Armed Forces?	X No	If Yes	s, specify Cuba	an, Mexican	, Puerto Ri	ican, etc.)	10-	White	etc.	
hours after natural", Examiner	3 VVIdowed 4 DIV	orced if Yes, Give Year or Dates:	nieted) 16a I]	Yes 2 X N s Usual Occup			de dono	1406	Specify:		ack
	Elementary/Secondary (0-12)		+)	during mos	st of working lif	e DO NOT	use retired	d)	16b.	Kind of Bus	siness/in	dustry
5-0036 lled within 72 Hygiene t other than the Medical	12 17. Father's Name (First, Middle	1 200		Paint	er	T				Pain	,	3
		, Last)				18. Mother Edna	s Name (F a Ton	irst, Middle .ey	, Maiden	Surname)		
MD 2121 d 2 should be fi tht and Mental n 27 is marked sumatic event,			19b	Mailing	Address (Stre	eet and Num	nber or Rur	al Route N	umber, C	ity or Town	State,	Zip Code)
- 0 H s = 1	20a. Method of Disposition	BOIL/ BISCE	20b. Place o	f Dispositi	Lariat			Date N		Location -		
늘 ~ % 늘 일	1 X Burial 2 Cremation 4 Donation 5 Other Si		te cremato	ory or othe Holin			11/1	0/200			-	Maryland
Baltimore, permit. Pages I an Department of Han Important: If iter injury or other tra	21. Signature of Funeral Service	Licensee		22. Na	me and Addres		Brin	sfiel	d Fu	neral	Hor	ne PA.
Physician.	Kyle S. Simons 23a, Part I. Enter the disease, or	complications that caused t	the death. Do no	t enter the	mode of dving	a such as co	ardiac or re	eniratory a	rroct ch	town	Mary	1and 2065 Approximate Interval
/Medical	failure. List only one cause Immediate Cause (Final disease	on each line. Dilated	cardiomy	opathy	complic	ated by	r chest	. injur	ies			Between Onset and Death
Adminier	or condition resulting in death)	Due to (or as a consec							,			
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):									
ted Insit	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):								-	
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8760, tiffcate be end physician as the burial m/Media	UNPENDED IF FEMALE:	AMENDED #23a	perME, go	362, 1	2/16/06	IT			22	d Date of a	Jalman	
∞ ‡ ≅ s } ⊑	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Feta		Ectopic	pregnanc	у	230	d. Date of d Month	Da	y Year
Box 6 e death cer the attendi ed for use:	1 Yes 2 No 9 Uni	known 9 Unknown	ime or death 5	Othe	er (Specify)							
P.O. Bries that the designed by the be detached by the bries by the bries by the bries by Physical by Physical by Physical bries by Physical by Physical bries by Physical bri		ions contributing to death	but not resulting	in the un	derlying cause	given in Pa	irt I.		_	-	_	e cause of death?
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Records, The law requires fricate has been signage 2 should be Completed								auto	opsy ormed?	pr de	ior to co eath?	mpletion of cause of
Ital Re- ician: The certificate rector, page		. 1			26.Plac	e of Death ((Check onl	1 Yes y one)	2 N	0 1	✓ Yes	2 No
f Vit Physic er this c ral dire	1 Yes 2 No		et 2 ER/Ou			Other ₄	Nursing F		Reside		Other:	
Division of Vital Records, P.O. Box 6 spiral or Attending Physician: The law requires that the death cerours after death neral Director: After this certificate has been signed by the attendiffer in by the funeral director, page 2 should be detached for use Certification: To Be Completed by Physicis	1 Natural 5 Pend 2 Accident Invest	stigation	ar) 1405		1	ury at Work? Yes 2 ✓	No Dr	d Describe	uto co	llision		
Divi ours after ours after filled in	3 Suicide 6 Coul	d not be rmined 28e. Place of Inju			factory, office	building, etc		or Town, oute 235 &	(Street a State) Mervel	nd Number I Dean Ro	or Rura	Route Number, City
the Ho hin 24 l the Fu		nysician: To the best of my miner:On the basis of exam	knowledge, dea	th occurre	d at the time, o	date and pla n, death occ	ce, and du	e to the cau	use(s) an	d manner a	s starte	<u> </u>
To with To com	29b Signature and title of certifie	and manner stated			29c Licen	se number			29d. l	Date signed	d (Monti	n, Day, Year)
	& Carter	Celle			0.0	.M.E.			Nov	ember 5	, 2006	
		ssistant Medical Exa	miner 111	Penn S	Street, Balti	more, MI	D 21201					
State Registra		2006 Registrar	s Signature	Soul	2							
DHMH 17 Rev 1/2001			ORI	IGINAL	195					_		

<u>.</u>	1 - For State Registrar		artment of Health and rtificate of Death	Reg. No.	06 36254
Physiciar /Medica	neulau c. niuwi	•		2. Date of Death October 23	2006 6:45P м
Examine		street and number)	4b. City, Town, or Location of Deal		unty of Death e Arundel
Funeral Director	5. Social Security Number 6. Security Number 11	7. Age (In yrs. last birthday) M 247 F 63 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country) 3 Maryland
aryland show dat	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits
deeth with the Maryland me 23a or 28a-f show rmust be notified at	Maryland Anne Al		10f. Zip Code		of What Country?
be filed within 72 hours after deeth with the Marylan tall Hygiene. Identity than "naturel", or tieme 23s or 28s-f show event, the Medical Examinat must be notified at		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 🕅 No	21401 Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 □ Yes 2€ No Specify:	to Rican, etc.)	A Race - American Indian, Black, White, etc. ecify: Black
ed within 72 hours after ygiene. Set than "naturel", or Ite Medical Examine.		Year or Dates:	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking 16b. Kind o	of Business/Industry
vid be filed within Wental Hygiene. Inked other than " Itic event, the Ma	17. Father's Name (First, Middle, Last)			Nurs me (First, Middle, Maiden Sur Smith	ing Home
Mary nd 2 shoul lith and M 27 is mar r treumati	19a. Informant's Name/Relationship (1) Ellen Offer (Dat	ype, Print) 19b. Mailin aghter) 701 G	the second secon	t 503 Annap	olis, Md.21401
Dattimore, permit. Pages 1 e Department of Hee Important: If Item any injury or othe	20a. Method of Disposition 1 ABurial 2 Cremation 3 4 Donation 5 Other (Specify	UM Chur		80-06 Anna	on - City or Town, State polis, Md.
Departing the permit Departing	21. Signature of Funeral Service Licen		Mame Reesse of & Son 21 West St. An		
bolysician /Medical Examiner sthe burial-transit	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		JE PENAL	1 -	Approximate Interval Between Onset and Death UCA: CA: CA: CA: CA: CA: CA: CA:
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law requires that the es been signed by the 2 should be detache	Partil: Other significant conditions of	entributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use of 1 Yes 2 N	contribute to the cause of death?
The The page				24a. Was an autopsy performed?	4b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
OT VICAL Physician: This certificatal director. pr		Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Other	ath <i>(Check only one)</i> Home 5 ☐ Residence 6 ☐	Other (Specify)
or Attending Physialise death. Director: After this in by the funeral di		28a. Date of Injury (Month, Day Year) 28b. Time o		28d. Describe how injury oc	
led led		building, etc. (Specify)		City or Town, State)	umber or Rural Route Number,
the Hosp hin 24 hou the Fune mpletely fil	29a. Certifier (Check only one) 29 Medical Exam 29b. Signatu/e and title of certifier	ysicien: To the best of my knowledge, deat itner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occurred.	urred at the time, date and pla	d manner as statedce, and due to the cause(s) gned (Month, Day, Year)
To Too		M-M	0 05072	5 10-6	4-2006
State	Jenni terkied	completed cause of death (Item 23a) (Type,	erans Hwy N	lillersv.ll	, MD 21/08

			1- For State of Maryland / Department of Health an Certificate of Death	nd Mental H	ygiene Reg. No	HIII	36255
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of I	Death Da	y Year	3. Time of Death
	/Media		Henry Meade Bareford, Jr.	Nov	7	2006	7:35 PM
	Examir	ner	4a. Facility Name (If not institution, give street and number) Genesis HealthCare - The Pines Easton	Death	40	County of Deal	
			Genesis HealthCare - The Pines Easton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of E	lirth	Talb	
	Funeral Director				Jau Year	24 Vir	thplace (State or Foreign buntry) GINICL
			Usual Residence of Decedent	11149 2	, ,,	21 100	92120
	irylan show	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
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	or 2	Dire	10e. Street and Number 10f. Zip Code			tizen of What Co	
	s 23e	rai	27701 Burrsville Road 21629				es of Americ
	item Item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 □ Married 1. □ Never Married 2 □ Married 1. □ Never Married 2 □ Married 1. □ Never Married 2 □ Married 1. □ Never Married 2 □ Married	n? (Specify Yes or N Puerto Rican, etc.)	10-	 Race - Ame Black, Whit 	
36	Ir, or	by F	3 Widowed 4 Doivorced Year or Dates: 7946			Specify:	og Lian
21215-0036	72 hours after death with the Maryland neturel', or Items 23e or 28a-f show disal Examinat must be routified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. K	and of Business/	Casian Industry
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p	be file ital Hy od oth	Be (17. Father's Name (First, Middle, Last)	Name (First, Midd	le, Maider	Sumame)	
yla	should be to dead Mental I	To	Henry Meade Bareford Milds	red Ruth 1	Bruba	ker	
Maryland	and is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of				
	of Health of Health item 27		Louise Bareford sister 9910 Tuckahoe Road,	Denton,			
10			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	Date	1	ocation - City or	
Baltimore,	2 7 7 7			1/13/2006	Den	ton, Ma	ryland
Bal	Dependent Depend		21. Sign flure Funeral Service Lights 22. Name and Address of Facility Moore Funeral Ho	me, P.A.			
	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ırdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and nd for use as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last C				
.O. Box	it the death certifice by the attending ph tached for use as ti	Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1			23d. Date of deli Month	ivery Day Year
S,	The law requires that the te has been signed by th age 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
Records,	w require been sig should b	Completed by	Anemia	_ 10	Yes 2	□ No 3 Pr	obably 4 Unknown
S	aw requ is been 2 should	piet	Striet frontation	24a. Wa		24b. Were au	topsy findings available
Ä	The lay te has page 2	E			opsy formed? 22 No	death?	completion of cause of 2 \(\subseteq \text{No} \)
ita	iicien: The certificate his rector, page	BeC	25. Was case referred to medical 26. Place of	Death (Check only		1	22,10
of Vital	S 0 10	10.	examiner? 1 Yes No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursi	ng Home 5 ☐ Res	sidence	6 ☐Other (Spec	cify)
	iding Phy th. After thi funeral		27. Magner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury at Work?	28d. Describe	how inju	y occurred	
0	endiversity or: Al	atic	2 Accident investigation M 1 Yes 2 No				
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or To	own, State)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and p and manner stated.	place, and due to the occurred at the time	e cause(s) e, date and	and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the complet	W	29b. Signature and title of certifier 29c. License number	022	29d. Da	te signed (Month	
)		Principle of the second	V 1997 1000 11259	197	,	11.8.0	76
			30. Name and address of person who completed caused death (Item 23a) (Type, Print) MICHAEL CROWLY, MA GIO DUTCHMANS A	ANE E	AST	on MD	21601
	Sta Regist		31. Date filed (Month) Day Year) 3 2006	•			

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Evelyn Lillian Buckmaster

_	Registrar C6	ertificate o			ı	Reg No		
ın/ ner	Decedent's Name (First, Middle,Last) Evelvn Lillian Buck	cmaster			2. Date of De Month October :	26, 2006	Year 202	e of Death 25 hrs
	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or		ath		inty of Death	
	<u> </u>	last hirthday)			Hrs 8 Date of B			(State or
	222 50 6726		Months Day		A in	,	Foreign	
ŀ		Y 15	S		00122	2 1945	Count NO. 1	oue 151
İ	10a. State 10b. County 10c. Cit	* .					10d Ir	side City Limits
5	Maryland St. Mary's Pa	ırk Hall					1	Yes 2X No
ect	10e. Street and Number		10f. Zip Code			_		
			20659			United	l States	
Jera								ian, Black,
	1 Yes 2 X No		Vec 2 X No	enecify:		Spec	white	
호	or Dates: 15. Decedent's Education (Specify only highest grade completed)				of work done			
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ם	12th	home	maker			own	home	
ပ၂	17. Father's Name (First, Middle, Last)						ame)	
		10h Mailia	a Address (Ct				T 0	10
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1		b. Place of Dispos	sition (Name of ce		Date			
	1 XBurial 2 Cremation 3 Removal from State			ct 30 2	2006	Princ	e Freder:	ick MD
-	4 Donation 5 Other Specify	_	-					
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							r heart Appro	oximate Interva
	T	cation					Detw	veen Onset and Death
	or condition resulting in death) Due to (or as a consequence	of):						
<u>_</u>	Sequentially list conditions, if any leading to immediate. Due to (or as a consequence	of):						
i i	cause. Enter Underlying Cause							
Xal	events resulting in death) Last Due to (or as a consequence	of):						
	TY							
edi	#2Jd,21,		rME, G861,	11/27/06	TT	22d Dat	to of dollware	
١	23b. Was decedent pregnant in the		etal death 3	Ectopic preg	gnancy			Year
Si	Pregnant at time of	death 5 0	ther (Specify)			, l		
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	Part is Other significant conditions continuously to death but no	t resulting in the	underlying cause (giveninranti				
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a	25. Was case referred to medical examiner?	# ED/Outnotion		Other	rsing Home 5	Residence	C 0#	
0	Tes 2 No	✓ ER/Outpatien 28b. Time of		ry at Work?		how injury oc		
	1 Natural (Month, Day, Year)	1		Yes 2 X No	unknow			
ion: T	5 Pending Fpd 10/26/200	Yol kmd /∗'	71 om l' 🗀			11		
fication: T	2 Accident Investigation 28e Place of Injury - At		LI CAII	- 11	28f. Location	(Street and Nu	umber or Rural Rout	te Number, City
ertification: T	2 Accident Investigation 3 Suicide 6 X Could not be determined (Specific) at hon-	t home, farm, stre	LI CAII	- 11	28f. Location or Town,	(Street and Nu State) (ar	ret Trailer	te Number, City Park
al Certification: T	2 Accident Investigation 28e. Place of Injury - At Accident Suicide 4 Homicide Check only - 1 Certifying Physician: To the best of my knowled to the control of the control	t home, farm, stre Scene edge, death occu	eet, factory, office burned at the time, di	ouilding, etc.	28f. Location or Town, Lot D-1	(Street and Nu State) Gar Lexingto use(s) and man	ret Trailer on Park, MD nner as started	Park
	2 Accident Investigation 28e. Place of Injury - At Accident Suicide 4 Homicide Check only one) 2 Medical Examiner: On the basis of examination	t home, farm, stre Scene edge, death occu	eet, factory, office burned at the time, di	ouilding, etc.	28f. Location or Town, Lot D-1	(Street and Nu State) Gar Lexingto use(s) and man	ret Trailer on Park, MD nner as started	Park
Medical Certification: T	2 Accident Investigation 28e. Place of Injury - At Accident Suicide 4 Homicide Check only - 1 Certifying Physician: To the best of my knowled to the control of the control	t home, farm, stre Scene edge, death occu	eet, factory, office burned at the time, di	ouilding, etc. ate and place, a	28f. Location or Town, Lot D-1	(Street and Nu State) Gar Lexingto use(s) and mar e and place, a	ret Trailer on Park, MD nner as started	Park
	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	t home, farm, stre Scene edge, death occu	eet, factory, office burned at the time, diation, in my opinior	building, etc. ate and place, a	28f. Location or Town, Lot D-1	(Street and Nu State) Gar Lexingto use(s) and mar e and place, at 29d Date s	rret Trailer In Park, MD Inner as started Ind due to the cause	Park
	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	t home, farm, stre SCENE edge, death occun n and/or investiga em 23a)	urred at the time, dation, in my opinior	ate and place, and the second	28f. Location or Town, Lot D-1 and due to the caud at the time, date	(Street and Nu State) Gar Lexingto use(s) and mar e and place, at 29d Date s	ret Trailer on Park, MD nner as started and due to the cause signed (Month, Day	Park
	Completed by Physician/Medical Examiner To Be Completed by Funeral Director	St. Mary's Hospital 5. Social Security Number 323-58-6736 Jusual Residence of Decedent 10a. State 10b. County 10c. Cit Varyland St. Mary's 10c. Cit Varyland 10c.	St Mary's Hospital 5. Social Security Number 323-58-6736 Mary 61	St. Mary's Hospital 5. Social Security Number 323-58-6736 Usual Residence of Decedent 10b. County 10c. City, Town or Location Park Hall 10c. State 10b. County 10c. City, Town or Location Park Hall 10c. State 10b. County 10c. City, Town or Location Park Hall 10c. State 10b. County 10c. City, Town or Location Park Hall 10c. State 10c. City, Town or Location Park Hall 10c. State 10c. City, Town or Location Park Hall 10c. State 10c. City, Town or Location Park Hall 10c. State 10c. City, Town or Location Park Hall 10c. State 10c. City, Town or Location Park Hall 10c. State 10c. City, Town or Location Park Hall 10c. City Code 20c. Siew Siew Siew Siew Siew Siew Siew Siew	St. Mary's Hospital Social Security Number 32.3 - 58 - 6736	St. Mary's Hospital Social Security Number 323-58-6736 1 M 2 XF 61	St Mary's Hospital S Social Security Number 323-58-6736 S. Sex 7. Age (in yrs. last birthday) If Under 19 Year If Under 24 Hrs. 8. Date of Birth(MMDDDY Months Days Hours Min Oct 22 1945 Usual Regidence of Decedent Van State Van Vary St. Ma	St Mary's Hospital St Mary's Hospital St Mary's Bocal Security Number 32.3 - 5.8 - 6.7 3.6 1/2

State of Maryland / Department of Health and Mental Hygien 206 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Hawes Clifford Boyd 25, 2006 10:45 P October /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funeral 1**X** M 2 □ F 63 Vrs May 8, 1943 Washington, DC Director 216-40-8272 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or Iteme 23a or 28a-f ehow the Madical Examiner must be notified at by Funeral Director 1 ☐ Yes 2X No Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9125 Sam Owings Place 20736 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Prince George's Elementary/Secondary (0-12) College (1-4or 5+) County Government Police Officer ith and Mental Hygis 27 is marked other r traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eldred Kevs Edith Robert Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ertment of Heelth a crtant: if Item 27 is injury or othar trai 9125 Sam Owings Place Owings, MD Teresa G. Boyd (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 2006 Clinton, MD permit.
Departri
Imports
any inju 21. Signature of Funeral Septem Liversee 22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 Southern Maryland Blvd. Owings, MD Mehrel W. 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mulhforme Priysician /Medical pendent Diabetes Mellitus Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t 1 Yes 2 2 No Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 25 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this : After this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation d in by the 3 Suicide 6 Could not be determined Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ò within 24 hours a
To the Funerel I
completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50 ann 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hospital Road, Suite 303, Prince Frederick, MD 20678 Parul S. Jani.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT

32. Registre's Signature

2006

		•	For State Registrar	State	/ Iviai ylai	-		te of De		Mental F	Reg. Ne	2006	36258
Н	Physicia	an	1. Decedent's Name (First, Middle, L							2. Date of Month	Death Da		3. Time of Death
	/Medic	al	Treva Jean								mber		
	Examin	er	4a. Facility Name (If not institution, g		imber)				ocation of Dea	ith	40	. County of Dea	
	Funeral		4309 Shore Rd 5. Social Security Number 6.	• Sex	7. Age (In yrs.	last birthday)		altin		s. 8. Date of	Birth		imore
ш	Director		220-80-6589	1 ☐ M 2 🔀 F	43	Yrs.	Months	Days	Hours Min	8. Date of (Month,	715,19	63	thplace (State or Foreign buntry) MD
	D .		Usual Residence of Decedent		10.00								
	anyla shov	_	10a. State 10b. County			y, Town or Lo							10d. Inside City Limits 1 1 Yes 2 14No
	Ne M	Director	MD Balti 10e. Street and Number	more	Ba	ltimor		0.1			10.00		
	with Bor	늅	4309 Shore Rd	i				Code				izen of What Co	ountry?
	ns 23	Funeral	11. Marital Status		edent Ever in U	.S. 13. \	_	1219 dent of Hispa	anic Origin? (Specify Yes or		S.A. 14. Race - Ame	erican Indian.
320	should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Hygiene marked other than "natural; or items 23a or 28a-f show marked other than "natural; or items 23a or 28a-f show matic event, it a Medical Examinar must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed F	orces? 2 ∑ No ive	'	fYes, spe 1 □ Yes	cify Cuban, I	Mexican, Pue Specify:	no Rican, etc.)		Black, White	e, etc.
21215-0036	2 hou	ted	15. Decedent's	Education		16a. Deced	dent's Usu	al Decupatio	n		16b. K	ind of Business	/Industry
212	thin 7	Completed	(Specify only highest g		1-4or 5+)	life.	DO NOT	nk done duri ise retired)	ing most of w	orking			
71	filed will Hygien ther th	Son	10	-		Hou	sewi					ouseholo	1
2	d ta b	Be	17. Father's Name (First, Middle, Las	st)				ł		ame (First, Mid		Sumame)	
Z	should bind Ment	၉	Lloyd D. Reeve			T				ine Har			
=	2 6 5		19a. Informant's Name/Relationship Brady Byers/Hus	. ,, ,								or Town, State,	Zip Code)
a)	1 end 2 Health tem 27 other tr		20a. Method of Disposition	Dario	20b. F	lace of Dispo	sition (Na	me of	, Balt	imore,		21219 ocation - City or	Town, State
<u> </u>	Peges nent of int: If it iry or o		1 Surial 2 Cremation 3 4 Donation 5 Other (Spec		State	emetery, crer ion Ce	natory or	other place)	Nov	ember 8		cton, MI	
altimore,	글로만큼		21. Signature of Funeral Service Lic	•	011	22	. Name a	nd Address o	of Facility	06		100117 111	
ñ	Depa Impo eny i		Lilio							eral Ho			
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that	caused the deat	h. Do not ent	er the mo	de of dying, s	such as cardia	ELKTON, ac or respirator	y arrest,	21921	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	iy 0.10 00000 011		cen i	lims	2					Onset and Death
	/Medical		resulting in death)	a. Due to	(or as a conseq		100,0)				······································	3 years 10
н	Examiner		Sequentially list conditions,	b									Wow C
	pe is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):							
3	and and il-tran	хап	that initiated events resulting in death) Last	c	(or as a conseq	neuce ot).							
8760,	icate be executed physicien and s the burial-transit			V	,								
		edical		a									
ŏ	death certifi e attending I od for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		7=					23d. Date of de	livery '
P.O. Box	0 0 2	SICIB	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 ☐ Feta nant at time of d]Ectopic p] Other (s				_	Month	Day Year
<u>т</u> О	at the	Phy											
rds,	The law requires that the ste hes been signed by th page 2 should be detache	<u>م</u>	Part II. Other significant conditions	s contributing to e	death but not res	ulting in the u	nderlying	cause given i	in Part I.	1	Yes 2		o the cause of death?
ဝ္	awre	Completed								24a. W		24b. Were a	utopsy findings available
Ť.	Physician: The lav this certificete hes ai director, page 2	E O								p 1□ Ye	utopsy erformed? es 2:⊊″No	death?	completion of cause of
=	stan: ertifica ctor,	Be	25. Was case referred to medical examiner?					2	6. Place of De	eath (Check on			
ita	_ % •	ဦ	1 ☐ Yes 25 No	Hospital:	Inpatient 2	ER/Outpatier	it 3□ D	OA Other:	4 🗌 Nursing	Home 5	esidence	6 ☐ Other (Spe	cify)
of Vital	hys his o	F					1	28c. Injury at		28d. Descri	be how inju	ry occurred	
n of Vital	ing Phys After this ouneral dir	on; T	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date (Mo	of Injury oth, Day Year)	28b. Time of Injury		28c. Injury at Work?					
on of Vita	After After funer	Ication; T	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date (Moi		Injury	М	1 🗆 Yes	s 2 No	296 Lecation	- (64	- / 1/	
on of Vita	After After funer	ertification; T	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date (Mon t be 28e. Ptac	of Injury oth, Day Year) e of Injury - At hilling, etc. (Specil	Injury	М	1 🗆 Yes		28f. Location City or	n (Street ar Town, State	nd Number or R e)	ural Route Number,
on of Vita	After After funer	Certification;	1 Natural 5 Pending investigat 3 Suicide 6 Could not 4 Homicide 29a. Certifier 1 Certifying 1	28a. Date (More to build a second control of the co	e of Injury - At h ding, etc. (Special e best of my kno	Injury ome, farm, str y) owledge, deat	M eet, factor	1 ☐ Yes y, office t at the time,	s 2 No	City or	Town, State) and manner a	s stated
on of Vita	After After funer	Medical Certification; T	1 Natural 2 Accident 3 Suicide 4 Homicide 199a. Certifier (Check only 2 Medical Ex	28a. Date (More to build a second control of the co	e of Injury - At h ding, etc. (Special e best of my kno	Injury ome, farm, str y) owledge, deat	M eet, factor	1 ☐ Yes y, office t at the time,	s 2 No	City or	Town, State) and manner a	s stated. e to the cause(s)
on of Vita	To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the tuneral directors.	Certification;	1 Natural 5 Pending investigat 3 Suicide 6 Could not determine 29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	28a. Date (More to build a second control of the co	e of Injury - At h ding, etc. (Special e best of my kno	Injury ome, farm, str y) owledge, deat	M eet, factor	1 ☐ Yes y, office t at the time,	s 2 No	City or	Town, State) and manner a	s stated. e to the cause(s)
on of Vita	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person where	28a. Date (More to build a second control of the co	e of Injury - At h ding, etc. (Special e best of my kno	Injury ome, farm, str y) owledge, deat	M eet, factor	1 ☐ Yes y, office t at the time,	s 2 No	City or	Town, State) and manner a	s stated. e to the cause(s)
on of Vita	After After funer	Medical Certification;	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date (More to build a second control of the co	e of Injury - At h ding, etc. (Specif e best of my kno basis of examina ner stated.	Injury ome, farm, str y) owledge, deat	M eet, factor	1 ☐ Yes y, office t at the time,	s 2 No	City or	Town, State) and manner a	s stated. e to the cause(s)

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Ragistrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** JOHN ROY EARL BROWN October 30, 2006 2:59 P^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6538 Browns Quarry Road Sabillasville Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Dec. 21, 19 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10₹M 2□ F 219-60-4299 45 Director 1960 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits Item 27 is marked other then "naturel", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be inclined at 1 ☐ Yes 2 ☐ No Maryland Frederick Directo Sabillasville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6538 Browns Quarry Road 21780 U.S.A. Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health end Mental Hygiene. Int: If item 27 ie marked other then "naturel", or items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Karl R. Brown Shirley E. Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda S. Brown / Wife 6538 Browns Quarry Road, Sabillasville, MD 21780 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of H Importent: If Its eny Injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Family Farm 11/3/06 Sabillasville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Huneral Service Licensee 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part1. Enter the disease or complications that caused the dea shock, or heart failure. List only one cause on each line Metastatic Immediate Cause (Final 10/96 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attanding physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ate hes been signed by the a page 2 should be deteched to 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe this certificate 1 ☐ Yes 2 ☑ No 1 Yes After this certification funeral director, p To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 29c. License number M0066174L

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of

Way nosboro, PA 17268

rson who completed cause of death (Item 23a) (Type, Print)

1 2006

Please Type or Print in Black Indelible Ink

Herman Lloyd Bra		haw I- For State	State of M	aryland	-			d Mental	Hygiene	20	06 3626
		Registrar 1. Decedent's Name (First,	Middle Leet		Cer	tificate of	Death		2. Date of De	Reg. No.	O Time of Dooth
Physician Medical Examine	" er	Herman L	lovd Brad	dshaw,	Jr.					Day Year er 4, 2006	3. Time of Death 1027 hrs
		4a. Facility Name (if not inst	itution, give street	and numbe	er)		4b. City, Town, or	Location of De	ath	4c. County of I	
		Prince George's F					Cheverly			Prince Ge	
Funeral		5. Social Security Number	6. Sex		Age (In yrs. Ia	ast birthday)	If Under 1 Year Months Day		<i>f</i> in	. F	9. Birthplace (State or oreign
Director		579-70-5715	1 X M 2	F		53 Yrs		3 Hours I	12/	25/1952	cwarsh., DC
8.	F	Usual Residence of Deceder 10a, State 10b, Co			100 City	Town or Locat	ion				10d. Inside City Limits
ow any			,		roc. Gity,	TOWN OF LOCAL			1.		1 Yes 2 No
yland y-f sh	핡	Maryland Pri	ince Geor	rge's			Cap1	tol Hei		10g. Citizen of What	
e Mar or 28s	Director	4715 He	ath St				Tot. Zip Code	20743		-	d States
auth with the Maryland items 23a or 28a-f show ust be notified at once.	L	11. Marital Status		las Decede	ent Ever in U.	S 13 W/s	s Decedent of Hi		Specify Yes or N		American Indian, Black,
ath w	Funera	1 Never Married 2		rmed Force	s?	If Y	es, specify Cuba	n, Mexican, Pue	rto Rican, etc.)	White,	
rer de		3 Widowed 4	Divorced If Yes,	Give Year	2 X No	1	Yes 2 v No	specify:		Specify:	D11-
urs af	함	15. Decedent's Education	Lor Date	es.	ompleted)	16a. Deceder	nt's Usual Occupa	tion (Give kind		16b. Kind of Busin	Black ness/Industry
72 ho	Completed	Elementary/Secondary (0)-12) Co	ollege (1-4 c	or 5+)	during m	ost of working life		retired)		
1036 vithin ene.	ᇤ	12th					Truck	Driver		P	rivate
21215-0036 and be filed within 7 Mental Hygiene. Marked other than event, the Medica	ပ္ခို	17. Father's Name (First, M	iddle, Last)					18.Mother's Na	me (First, Middle	, Maiden Surname)	
d be f fental fental	Be	Herman	Lloyd B	radsha	aw. Sr		Address (O)		Barba	ra Bradsh	aw
MD 2 d 2 shoul lth and N n 27 is n aumatic	ř	19a. Informant's Name/Rela		j.		1					
	ŀ	Jeannetta 20a. Method of Disposition	Chatman	Siste	20b. F	Place of Dispos	Heath sition (Name of ce	emetery,	Date Date	ights, MD 20c. Location - C	20743 City or Town, State
Baltimore, permit. Pages 1 ar Department of He Important: If the njury or other tr		1 X Burial 2 Cren	nation 3 Rei	moval from	Clate	crematory or of					
Baltimo permit. Page Department o Important: injury or oth	1	4 Qonation 5 Oth 21. Sign ture Funeral Se		۸	<u> Re</u>	surrect	ion Cem	etery 1	1/17/200	6 Clin	ton, MD
Balt permit Depart Impor injury		(C)	Store	tion	111 -				Stewa	rt Funeral Wash DO	
Physician		23a. Part . Enter the diseas			ed the death.	. Do not enter t	he mode of dying	, such as cardia	c or respiratory a	rrest, shock, or hear	Approximate Interval
/Medical		failule List only one o	T) 7		emboli	sm compl	icating mu	ltiple in	juries		Between Onset and Death
Examiner	-	or condition resulting in dea			nsequence of			•			
	اي	Sequentially list conditions		(nsequence of	0.					
	릙	if any, leading to immediate cause. Enter Underlying C	ause	(or as a cor	nsequence of	π):					
_ =	Examiner	(Disease or injury that initial events resulting in death)	ned -	(or as a cor	nsequence of	f):					
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certificate be executed rentificate by executed rending physician and use as the burial - transit	edical	X UNPENDED	X AME	NDED #1	1,23a,27	7,28a-f,	perME, g86	52, 12/14,	/06 TT_	•	
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To To Con	ĕ	29b. Signature and title of o		nanner state	ed.		29c. Licen	se number		29d. Date signed	(Month, Day, Year)
		arias	~				0.0	.M.E.		November 5	, 2006
R		30. Name and address of p	erson who comple	ted cause o	of death (Item	n 23a)					· · ·
		Ana Rubio MD.	Assistant Me				Street, Baltim	ore, MD 212	201		
Sta		31. Date filed (Month, Day.	Year)	32. Regis	trar's Signatu	ure A					
Registr	ar	NOV 082	LUUU DE	men	10.	y					

			For St State Registrar	ate of Maryland		artment of He tificate of L			eng 006	36261
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Raymond Ensor Beach	III				Novembe		1125 AM
	Examin		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ith ,
			Washington County 5. Social Security Number 6. Sex	Hospital 7. Age (In yrs. la	o t trintale ()	Hagers If Under 1 Year	town If Under 24 Hrs.	O. Data of Righ	Washir	
	Funeral Director		5. Social Security Number 6. Sex 1区M 1区M 1区M 1区M 1区M 1区M 1区M 1区M 1区M 1区M			Months Days	Hours Min.	8. Date of Birth (Month, Day, Y		thplace (State or Foreign ountry) aryland
	land		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
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	or 28e	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What C	ountry?
	th wil	alo	105 N. Edgewood Dri	ve-Apt. 12		21740			USA	
-000	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mantal Hygiene. Item 27 le marked other than "naturel", or Items 23a or 28e-1 ehow other treumatic event, the Madical Exal, her mad the notified a	by Funeral	1 □ Never Married 2 ☑ Married 1	Vas Decedent Ever in U.S rmed Forces? ☑Yes 2 ☐ No Yes, Give ear or Dates:		Was Decedent of His f Yes, specify Cubar I ☐ Yes 2 ☆ No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
5	72 ho natur	eted	15. Decedent's Education (Specify only highest grade con	n npleted)	16a. Deced	lent's Usual Occupa	ition furing most of work	ing 16	b. Kind of Business	Mindustry
7	han.	Completed	Elementary/Secondary (0-12)	ollege (1-4or 5+)		kind of work done d OO NOT use retired))	C	onvenienc	e Store
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_	should I nd Men n marks umatic	ဥ	19a. Informant's Name/Relationship (Type, F		19b. Mailir	ng Address (Street a			City or Town, State,	Zip Code)
Σ	and 2 sealth as m 27 le		Susan C. Beach/Wife		105	N. Edgewo	od Drive	Apt.12,	Hagersto	wn, Md.21740
ē,	es 1 a of Hea of Hea f Item r othe	İ	20a. Method of Disposition	20b. Pl		sition (Name of natory or other place			c. Location - City of	
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a	permit. Pages Depertment of Importent: If I eny Injury or one		21. Signature of Funeral Service Licensee	'-		-			Funeral	
מ	\$ \$ £ \$ 8		+ Small Supp		16	01 Pennsy	ylvania A	venue, H	agerstown	, Md 21742
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	411		30. Name and address of person who completely the state of the state o	ated cause of death (Item 251 East	23a) (Type, Anti	Print)	1.	Hag. n	16 21	140
	Sta Registi		31. Date filed (Month, Day, Vear) NOV 1 5 2006	32. Agistrar's Signat	ure	melle				

	•		1 - For State Registrar	State of Maryla		rtment of H			giene 006	36262
			Decedent's Name (First, Middle, Las.)	0				2. Date of Dea	ath	3. Time of Death
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	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	th	4c. County of De	
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	Funeral		5. Social Security Number 6. Se	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h 9. B	irthplace (State or Foreign Country)
	Director		5/8-54-3693	□м 252 г	66 Yrs.	Day's	Tiours Iviii			Wash.,DC
	pue *		Usuel Residence of Decedent 10a, State 10b, County	10c.	City, Town or Loc	ation				10d. Inside City Limits
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ဗ္ဗ	el', o	b	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐Yes 21xx No	Specify:		Specify:	ack
21215-0036	within 72 hours after ene. than "naturel", or Ite	Completed	15. Decedent's Edu (Specify only highest grad		16a. Decede	ent's Usual Occupa	ation	rking	16b. Kind of Busines	
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<u>\</u>	should nd Men marke umatic	၉	Walter Tate					y Winst		
Maryland	C/ 40 = 6	0.3	19a. Informant's Name/Relationship (T)			Address (Street a		ural Route Numbe	r, City or Town, State,	Zip Code)
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ag	permit. Pages Department of t Important: If Ite any Injury or ot once.		21. Sign sture of Funeral Service Licens	600	22.	Name and Addres	110		Edwards	
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۲			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each line.	eath. Do not ente	r the mode of dying	g, such as cardia	c or respiratory ari	rest,	Approximate Interval Between Onset and Death
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Вох	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date of de	alivery
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>	Physic this ce al direc	10	examiner? 1 □ Yes 25 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA Othe	ar: 4 Nursing H	lome 5 ☐ Resid	ence 6 ☐Other (Sp	ecify)
Division of Vital Records,	ng Pt fter tt neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	28c. Injury Work	at	28d. Describe h	ow injury occurred	
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	n	1	30. Name and address of person who co	ompleted cause of death (tem 23a) (Timo P	rint)	1010	/	111 +10	0
	3		Prince George 's H	issoital (te	30	901 HOSP	TAL DA	R CH	EVERLY M	D 20185
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	* Registr	ar	NOV 1 5 200	6 Stephen	It hoe	de la				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** October 23, 2006 12:56A Cohen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Potomac Valley Nursing Home Montgomery Rockville If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 AM 2 □ F Yrs. 5-7-1934 Director 72 260-44-9514 Georgia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, Slate r than "natural", or items 23s or 28s-f ehow the Modical Examiner must be notified at 1 AYes 2 No Directo Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 10216 Ten Book Drive 20901 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🐴 No Il Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White aitimore, Maryland 21215-0036 1 ☐ Yes 2 A No ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Physician Medical of Health and Mental Hygie if Item 27 te marked other to other treumatic event, the permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked oth any injury or other treumatic event sine. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Benjamin Phillip Cohen Sara Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Sheldon Cohen - brother Atlanta, GA 30327 881 Summerset NW 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition Judean Mem. Gardens 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10-25-06 Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Na Denovanskoy FaGoldberg Memorial Chapels, Inc. 21. Signature of Fune at Service Licensee 1170 Rockville Pike Rockville, MD 20852 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Approximate Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YOMAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□ Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed this certificate 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Hospital: 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatienl 3 DOA Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Hospitei 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20062435 who completed cause of death (Item 23a) (Type, Print) Weditalate De 31. Date filed (Month, Day, Year) State 1 Registrar

December Some First Name Prince Some So			1	For State Registrar	State of Maryla		artmer			nd Me		giene Reg. No.	200	6	36	264
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9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No No Probably 4 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No No Probably 4 Unknown 25. Was case referred to medical examiner to Death (Check only one) 27. Manner of Death (Check only one) 28b. Time of Injury A Month, Day Yest Description of cause of death (Check only one) 28c. Place of Death (Check only one) 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner as stated. 28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner as stated. 28d. Certifier 28d. Certifier 28d. Certifier 28d. Certifier 28d. Certifier 28d. Certifier 28d. Certifier 28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner as stated. 28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner stated. 28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner stated. 28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner stated. 28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner stated. 28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner stated. 28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner stated. 28d. Describe how injury occurred at the time, date and place, and due to the ca	9	ertific ding p	Mec	IF FEMALE:	to If was outcome of or	agnancy										
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State Stat		s that ned b e deta			•			cause giv	en in Part I.		23e. Did t	obaccoι	ise contribut	e to the	e cause of	death?
State Stat	ıd	equire en sig outd b	ed b	Chronic Obstructi	ve Pulmona:	ry Disea	ase				1 🗆	Yes 2	No 3□] Proba	ıbly 4 □]Unknown
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			For State	State of Maryla	and / Dep	artmer			ental Hygi	ene	06	36265
			Registrar 1. Decedent's Name (First, Middle, Last)			runca	e oi Deaiii		Re 2. Date of Death		00	3. Time of Death
	Physici	an		01 0					Month	Day	Year	
	/Medi		Harry William 4a. Facility Name (If not institution, give s		<u>r. </u>	4h City	Town, or Location of		ctober		2006 ty of Death	2:30 P ™
	Examir	ner				40. Oity						
	Cunaval		Washington Count 5. Social Security Number 6. Sex		rs. last birthday	/) If Unde	Hagerstow	In 4 Hrs. E	B. Date of Birth	W	ash i no	
	Funeral Director			M 2□F 6.		Months	Days Hours	Min.	B. Date of Birth (Month, Day, pril 27	Year) . 1943	Cour	place (State or Foreign htry) Mary Land
	g.		Usual Residence of Decedent								-	
SS	irylar show		10a. State 10b. County	10c. (City, Town or L	ocation					1	lod. Inside City Limits
5	e Ma	ct	Maryland Washingt	on	Shar	psbur	g					1 ☐ Yes 2 📉 No
>-	with the Maryland a or 28a-f show the natilised at	Funeral Director	10e. Street and Number			10f. Zi	Code		10	g. Citizen o	What Cour	ntry?
ANEY	ath w	B	16808 Taylor's L				21782				US	
£	er de	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No 1 ⊆	U.S. 13.	. Was Dece If Yes, spe	dent of Hispanic Origii cify Cuban, Mexican, I	n? (Speci Puerto Ri	fy Yes or No- can, etc.)		ace - Americ ack, White,	
	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	966	1 🗆 Yes	2 No Specify:			Spec	ity: V	Vhite
5-0036	hou	ed	15. Decedent's Educ			edent's 13sı	al Occupation			6b. Kind of		
7 215	in 72 n "na	plet	(Specify only highest grade	completed)	(Give	e kind of wi DO NOT L	ork done during most d	of working	,	ob. King of	0031110334111	dustry
252	with piene	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Grind	lina M	achine Ope	rato	r	Truck	Manuf	acturer
7 5	e filed Il Hygi other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Middle, M	laiden Suma	me)	oc rur er
<u>a</u>	Ald be Alenta Alenta Treed tic sy	To B	Harry Chaney				Chris	tina	Mae	Stale	/	
WILLIAM Maryland 2121	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelth and Mental Hyglene. If marked other than "natural", or items 23a or 28a-f show other trsumatic svent, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mail	ling Addres	(Street and Number	or Rural I	Route Number,	City or Tow	n, State, Zip	^{Code)} 21782
	1 and 2 Heelth a		Mary K. Chaney -	Wife	1680	8 Tay	lor's Land	ing	Rd. Sha	rpsbur	a. Ma	ryland
JARRY altimore,	of He fitem		20a. Method of Disposition 1 XX Surial 2 Cremation 3 Re	206	. Place of Disp cemetery, cre	osition (Na	me of other place)	Da		Oc. Location		
	permit. Pages Depertment of Important: If is eny injury or once.		4 □ Donation 5 □ Other (Specify)	omoval nom state			m. Park No	v.1,	2006 Н	acers	town.	Maryland
at #	permit. Depertr Imports eny inje		21. Signature of Funeral Survive License				ned Fenterend					21795
_ <u>'</u> _ @	88 = 8		1 into	V	4	25 S.	Conocoche	ague	St. Wi	lliams	sport,	Maryland
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the de	ath. Do not en	nter the mo	le of dying, such as ca	ardiac or	respiratory arre	st,		Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition	BRONCHO	1500	~	PAIR	1 10/	0.110			Onset and Death
5	/Medical		resulting in death)	Due to (or as a cons	equence of):	-(+11		2010	1010114			OBDEN
2:34	Examiner		Sequentially list conditions	DIFUSE L	DEGF	B-C	ELLLYM	PHO	MA.	ST7+61	TV	1 MONTH
<u> </u>	p ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a conse	equence of):		189.020					
. 8	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
06,	ate be executed sysicien and he burial-transit		resulting in death / cast	Due to (or as a conse	equence of):							
30	ate b hysic	dical	d								-	
20 x 68	leath certificat attending phy I for use as the	Physician/Med	IF FEMALE:							F	- 11	
Box	death or e attend ed for us	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1☐Live birth 2☐Fe	etal death 3	□Ectopic p					ate of delive	ery Day Year
28	0 0	Sic	1 ☐ Yes 2 X No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	f death 5	Other (s	pecify)					Day . Gai
(8 °	hat the d by	P.	Part II. Other significant conditions con	tabuting to death but not a	aculting in the	doch in a	anne anne is Dest I		22a Did tab	2000 1100 00	ntelbuta ta ti	ne cause of death?
ds,	requires that the death een signed by the atte hould be detached for	1 by	Tarris on on organization of the	induiting to doubt but not the	oscining in the	unuanying i	ause given ar Fait i.		_	2 □ No	3 Prob	
OBE Record	requ leen houl	Completed										. ~
O.B.	B 8 C	현							24a. Was an autopsy perform		. Were auto	psy findings available mpletion of cause of
	: The cete had	S								No No	death?	2 🗆 No
Vital	Physician: The law this certificete has b ral director, page 2 st	Be	25. Was case referred to medical examiner?	ospital: 🛶			7	f Death /	Check only one)		
9	this le	2	1 Yes 2 No	1 Jounnation 2	☐ ER/Outpatie				5 Resider			v)
	eth. eth. rr: After se funer	- S	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c. Injury at Work?	i	d. Describe how	w injury occu	irred	
Division	deeth deeth ctor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home form of		1 Yes 2 No		f Location (Str	not and Num	har or Our	i Route Number.
Š	efter Direction by	ET.	4 ☐ Homicide determined	building, etc. (Spe	cify)	treet, tactor	y, office	20	City or Town,	State)	iber or Hura	i Houte Number.
_	To the Hospital or Attending F within 24 hours eiter deeth. To the Funeral Director: After completely filled in by the funer.		29a. Certifier 1 Sertifying Phys	ician: To the best of my k	mowierths for	ith converse	at the time date and	riano en	d due to the en	nendel and -	inner er er	mbat.
	24 h 24 h Fur etely	Medical	(Check only 2 Medical Examinone)	er: On the basis of exami	nation and/or i	nvestigation	, in my opinion, death	occurred	at the time, da	te and place	, and due to	the cause(s)
_	To the within 2 To the complet	¥ e	29b. Signature and title of certifier			29	c. License number		29	d. Date sign	ed (Month,	Day, Year)
	F > F 0		(00.2)c1 = -	_	ma12	11	7 0	efeste	30	,2006
			30. Name and address of person who con	mpleted cause of rieath III	em 23al ITvna	. Print)	DOO6?	. 6	7		,	
03	4-7+1		Alice Andriol	U- ESIDEY	7020	1113	300 Pale	ruc	Howar	そしの	MP	121740
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	Regist	rar	OCT 3 1 200	6	A. A.	23 436 3						

06-08054 Mildred Katherin	a C				n Black Ind				
Milated Ratifelli	ie Oi	onstable _{Amend} #8 State of M I-For State Registrar WCHD/SH 10/31/06	aryland/L ber FH	Certificate	of Health ar	na ivientai	ı Hygiene Reg	No. 200	6 36266
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last) MILDRED CONSTABLE					2. Date of Death Month October 26	Day Year	3. Time of Death 0912 hrs
		4a. Facility Name (if not institution, give street Washington County Hospital	and number)		4b City, Town, o		eath	4c. County of Deat Washington	h
Funeral Director				n yrs. last birthday	Yrs. If Under 1 Ye		4Hrs 8 Date of Birth Aug. 5,	(MM/DD/YYYY) 9. Bi 1930 Forei 1920 Co	
an'.		Usual Residence of Decedent 10a State 10b. County	100	c. City, Town or Li	ocation				10d. Inside City Limits
Maryland 28a-f show	for	MARYLAND WASHINGTO	N			R SPRIN			1 Yes 2 XNo
ith the Mar 23a or 28a notified at	Director	11735 ROCKY MEADOW R	.OAD		10f. Zip Code	1722	100	Citizen of What Cou	.S.A.
r death w or items must be	Funeral	1 Never Married 2 Married A	/as Decedent Evermed Forces? Yes 2 X		If Yes, specify Cuba	an, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
hours afte 'matural'', Examiner	d by	3 X Widowed 4 Divorced of Pate 15. Decedent's Education (Specify only high	S.		Yes 2 X N	ation (Give kind		Specify: WI 6b Kind of Business	HITE /Industry
136 hin 72 hours al e than "natural edical Examin	Completed	Elementary/Secondary (0-12) Co	llege (1-4 or 5+)	- durir	g most of working lif HOMEM		e retired)	OLINI I	IOME
1215-0036 Id be filed within 72 dental Hygiene narked other than "		17. Father's Name (First, Middle, Last)			HOTHER	18 Mother's N	lame (First, Middle, Ma	iden Surname)	HOME
2121 uld be fi Mental I marked c event,	To Be	EDWARD MASON COULTER 19a Informant's Name/Relationship (Type, Pr		19b. Ma	ailing Address (Stre		HE MARIE K		e Zin Code)
MD id 2 shoulth and m 27 is		NICOLE LYNN LUM, GRA	NDDAUGHT	CER 11	735 ROCKY	MEADOW	ROAD, CLE	AR SPRING,	MD 21722
Baltimore, MD 21215-003 permit Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other injury or other traumatic event, the Med		20a Method of Disposition 1 X Burial 2 Cremation 3 Rer	noval from State	crematory of	sposition (Name of corrections) AWN MEM.]		0/31/2006	20c. Location - City o	
Baltim permit Pa Departmer Importan		4 Donation 5 Other Specify 21 Signature of Funer Service Licensee			2. Name and Addres	ss of Facility	7606 0	HAGERSTON LD NATIONA	WN, MARYLAND
m ឧភ≛.≊ Physician		23a. Par Venter the disease, or complication	s that caused the	death Do not en	BAST FUN		BOONSB	ORO. MARYI	AND 21713 Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a Pulme	onary Thromb		,,,,	,	,,	4 511551, 51 11561	Between Onset and Death
-		ь Bilate	or as a conseque					-	
	iner	cause. Enter Underlying Cause	(or as a conseque	ence of):	<u>.</u>			-·	
ed nsit	Examiner	events resulting in death) Last Due to	(or as a conseque	ence of):					
e evecuted cian and rial - transit	ical	d. UNPENDED AME	NDED	-					
8760, tificate bung physicas the bungas the	sician/Med	IF FEMALE: 23c. 23c. 1 23c. 1	If yes, outcome of	of pregnancy	Fetal death 3	Ectopic pro	egnancy	23d Date of deliver	Ty Day Year
ords, P.O. Box 68760, w requires that the death certificate be ensigned by the attending physiciar should be detached for use as the burial	Physicia	1 Yes 2 No 9 Unknown g	Pregnant at time Unknown		Other (Specify)				
P.O. es that the ligned by be detacl	Σ Ω	Part II. Other significant conditions contrib	uting to death bu	it not resulting in t	he underlying cause	given in Part I		2 No 3 Pro	the cause of death? bably 4 Unknown
5 g g g C	ompleted						24a Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
tal Rections: The certificate	Be Co	25 Was case referred to medical examiner?			26 Plac	ce of Death (Ch	0 1	No 1 Y	es 2 No
n of Vital F ding Physician: 1 After this certific funeral director, p	ျ	1 ✓ Yes 2 No	a. Date of Injury	2 ER/Outpat		Other No	ursing Home 5 R	esidence 6 Othe	er:
ion c tending eath tor: Af the fun	ation	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)			Yes 2 No		y occurred	
Division at or Attend s after death it Director: ed in by the t	Certification:	3 Suicide 6 Could not be	le. Place of Injury	- At home, farm,	street, factory, office	building, etc.	28f, Location (Str or Town, Sta		ural Route Number, City
Di To the Hospital A Within 24 hours a To the Funeral I	cal Ce	29a Certifier (Check only 1 Certifying Physician: To	the best of my kn						
To the within 2 To the complet	Medical	one) 2 Medical Examiner: On the and m 29b Signature and title of certifier	anner stated	ation and/or inves		on, death occurr		id place, and due to the place of the place	
		Talmusias	SAR	١		M.E.		October 27, 200	
₩-5		30 Name and address of person who completed Zabiullah Ali, M.D. Assistant	ed cause of death Medical Exan		Penn Street, Ba	ltimore. MD	21201		
S	tate	31 Date filed (Month Pay Year) 2006	32. Registrar's S	Signature					
Regis	trar	001 0 0 2000	J. Harten	1. J.	perse				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes of Action 1.

			For State Registrar		State of M	Ce	artment of H rtificate of l			ene 2006	36267	
	Physici	an	1. Decedeni's Name (2. Date of Death Month	Day Year	3. Time of Death	
	/Medic				her Cribb				October	24, 2006	6:36 P M	
7	Examir	er	4a. Facility Name (If n)		Location of Death		4c. County of Death		
			8511 Tart					eake Beac		Calve		
	Funeral Director		5. Social Security Num 577-72-00	090	X 7. A	ge (In yrs. last birthday, 53 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct 27,	of Birth 1, Day, Year) 9. Birthplace (Sta Country) 27, 1952 Washingt		
	aryland how	_	58.5	10b. County		10c. City, Town or L					10d. Inside City Limits	
	8a-f	cto	MD	Calve	ert	Chesapea	ke Beach				1 ☐ Yes 2X No	
	or 2	Dire	10e. Street and Numb				10f. Zip Code		10	g. Citizen of What C	•	
	ath v	rai		rtan Cou			1	0732		USA		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itiam 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic avant, it a Medical Examinar must be incitiled at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4		12. Was Decedent Armed Forces 1 Yes 2X If Yes, Give Year or Dates:		Was Decedent of Hilf Yes, specify Cuba 1 ☐ Yes 201 No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi		
5	72 h	etec	1 (Specify	5. Decedent's Ed	ucation de completed)	(Give	dent's Usual Occupa	during most of work	ting 1	6b. Kind of Business	/Industry	
2	within lene. then	mpi	Elementary/Second	Jary (0-12)	College (1-4or	5+)	DO NOT use retired	1)		Tone	lacenina	
	filed v Hygie other t		17. Father's Name (Fi	iont Adielella (not)	4	Ца	ndscaper	40. Marks and Marks	- (Fire Adiable 1		lscaping	
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Ž	should ind Men marke umatic	ဥ	Arthur 19a. Informant's Nam		ribbs	10b Mail	an Address (Street	Alice		City or Town, State,	stings	
Maryland	d 2 sho th and to my traum		Sallie Cr	, ,			Tarton Co					
	1 and Health tem 27		20a. Method of Dispos		rie)		osition (Name of matory or other place			Beach, MD	20732 Town, State	
Baltimore,	permit. Pages 1 and 1 Department of Health Important: if itam 27 any injury or other tr once.		1 ☐ Burial 2 ☑ 4 ☐ Donation 5	Cremation 3 Other (Specific	Removal from State	'		1	26			
₹	permit. Pag Department Important: i any injury c		21. Signature			Lee Cren	2. Name and Addres	200 ss of Facility		Clinton,	Maryland lvert, PA	
Ba	permit. Departr imports any inj) / Ga	ry J. G	off	8	125 South	nern Mary	land Blv	d. Owings	s, MD 20736	
			23a. Part 1. Enter the shock, or heart	disease, or comp failure. List only o	lications that cause one cause on each	d the death. Do not en line.	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between	
1	Physician		Immediate Cause (Fi disease or condition	inal	, /	1etachat	ic Es	phage	il Ca.	nce	Onset and Death	
	/Medical Examiner		resulting in death)		Due to (or as	s a consequence of):		1				
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_	and and II-tran	Examiner	that initiated events resulting in death) La	st	c. Due to (or as	s a consequence of);						
68760,	ificate be executed g physician and as the burial-transit	aiE										
387	ificate g phys as the	edicai			đ							
.O. Box (The law requires that the death certif te has been signed by the attending tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ I 9 ☐ Unknown	onths?		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	olivery Day Year	
Ω.	that the ded by deta		Part II. Other significa	ant conditions co	ontributing to death	but not resulting in the o	Inderlying cause give	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?	
rds	tuires n sign	d by							1 ☐ Yes	s 2 No 3 P	robably 400 known	
Records,	w require been si should?	ete							24a. Was an	24h Were a	utonsy findings available	
Be	ding Physician: The lav h. After this certificate has funeral director, page 2	Completed							autopsy	prior to death?	utopsy findings available completion of cause of	
tal	ifficat or. pi	ပိ	25. Was case referre	d to medical				35 Place of Dear	1 ☐ Yes 2 th Check only one		s 2 No	
of Vital	Physician: this certific ral director.	ToB	examiner? 1 ☐ Yes 2 ☑ N	T I	Hospital:	ient 2 ER/Outpatie	nt 3 DOA Othe		11 5 5 5 5 5 5 5	nce 6 □Other (Spe	20/6/1	
0	g Phy er thi		27. Manner of Death		28a. Date of Inj (Month, D				28d. Describe ho		ecny)	
<u>o</u>	Attending r death.	atio	Natural 2 Accident	5 Pending investigation		ay Year) Injury		Yes 2 □ No				
Division	ar de racto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	289. Place of It	njury - At home, farm, st	reet, factory, office		281. Location (Str. City or Town,	eet and Number or F	ural Route Number,	
	s afte	Cert	7 (2) 7 (3) (1)		Dullang, e	ic. (Specify)			City of Town,	State)		
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai	29a. Certifier (Check only 2 one)	Certifying Phy Medical Exam	ysician: To the bes iner: On the basis and manner s	t of my knowledge, dea of examination and/or in tated.	th occurred at the time evestigation, in my of	ne, date and place, pinion, death occur	and due to the cared at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and tit	tle of certifier	1		29c. License	e number	29	d. Date signed (Mon	th, Dey, Year)	
	- > - 0		•		1/1/	12	D	33125		Ondolo 04	0000	
	,		30. Name and address	s ol person who	completed cause of	death (Item 23a) (Type				October 20	o, 2006	
	6							Suite #3	10. Drin	ce Freder	ick, MD 2067	
	Sta	ate	31. Date filed (Month,	Day, Year)	32. Regisi	trads Signature		Surve #5	TO LITTE	CC TICUCI.	1011 MID 2001	
Ā	Regist			nct 2	7 2006	Homerce H.	bortes					

State of Maryland / Department of Health and Mental Hygien [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Sherman Oliver Coates 11:55 P M Oct 24, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie 7836 Parke West Drive apt. 201 Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Director Yrs 220-16-7331 81 Jan 2, 1925 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at Director 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7836 Parke West Drive apt. 201 21061 U.S.A. by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked oth any liquy or other traumatic event ODEs. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Zeanette Jones John Coates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maggie Crawford/companion 7836 Parke West Drive apt. 201 Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/28/06 Chesapeake Beach, MD St. Edmonds UMC Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Glady Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician mas /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) cete hes been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE . If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes autopsy performed? 1 Yes 2 No 1□ Yes 2. No 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 28 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After s efter dea... 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in within 24 hours e To the Funeral C 1 or Certifying Physician: To the best of my knowledge, death cooured at the time, date and place, and due to the cause(s) and manner as stated.
 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestyate Vav ONICK, 31. Date filed (Month, Day, Year) 32. Registra Signature State Registrar 2 6 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For Amend #5 Per Per FH 0862 12/01/06 JH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 07, 2006 Frances Lucille Charlton 2:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Washington Homewood at Williamsport Social Security Number If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 203-18-8383 Director July 16,1919 OK Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ıral", or Items 23a or 28a-f show Ex-miner must be notifled at 1 X Yes 2 ☐ No Directo MD Washington Hancock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 255 Maryland Avenue 21750 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify. <u></u> 3 ₩idowed 4 Divorced "natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other than any injury or other traumatic event, the once. 12 <u>Administrative Assistant</u> University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Olive Teressa Ingram Ezra Luther Pittman ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13803 Maple Ridge Hancock, MD 21750 David Pittman/Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21 Signature of Funeral Service Licensee Tonoloway Baptist 11 11/10/06 Needmore, PA 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or contain that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ears /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🙀 No Frances Lucille Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA WINursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 24 hours after deatl Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 29b. Signature and title 10 person who completed cause of dem (Item 23a) (Type, Print) State Registrar

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Chartton

			For	•	epartment of Health and	Mental Hygier		0.5070
			= State Registrar		Certificate of Death	Reg. I	<u> 2006</u>	36270
	Physici	an .	Decedent's Name (First, Middle, La.	•			Day Year	3. Time of Death
	/Medic	al	Bessie Mary	Carlson			3, 2006	1:30 A M
	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	lh .	4c. County of Death	ר
	Francis		5. Social Security Number 6. S	Memorial Hospital ex 7. Age (In yrs. last birth	Oakland day) If Under 1 Year If Under 24 Hrs	8. Date of Birth	Garrett 9. Birth	nplace (State or Foreign
	Funeral Director				rs. Months Days Hours Min	. (Month, Day, Ye	ar) Cou	intry) inois
	p _		Usual Residence of Decedent			15,	1707 111	
	aryiar show	-	10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits 1 X Yes 2 ☐ No
	he M	Director	MD Garre	it Mtn.	Lake Park	10-	Citizen of What Co	
	with la or			Annomico				,
	ns 23	Funerai	1608 Pittsburgh	12. Was Decedent Ever in U.S.	21550 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer		ited Stat	rican Indian,
۵	after o		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give		to Rican, etc.)	Black, White	e, etc.
5	be filed within 72 hours after death with the Maryland tal Hygiene d other than "neturel", or Items 23a or 28e-f show event, I're Medical Examinar must be notified at	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Whi	lte
2	"netu	Completed	15. Decedent's E (Specify only highest gra	de completed) (Decedent's Usual Occupation 'Give kind of work done during most of wo life. DO NOT use retired)	nrking 16b	. Kind of Business/l	Industry
7	withir ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker	0	wn Home	
2	fited Hygin Sther ant, 1		17. Father's Name (First, Middle, Last,			me (First, Middle, Maid		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "neturel", or liems 23a or 28e-f show the marked other than "neturel", or liems to rediffed at ematic event, the Medical Examinating must be notified at	To Be	Ernest P.	Strong	Mary	Wa	lker	
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Mailing Address (Street and Number or R	ural Route Number, Cit	ty or Town, State, Z	(ip Code)
	and 2 salth a n 27 Is		Marilyn Filemyr		08 Pittsburgh Ave,		ark, MD 2	21550
ore	of He		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □	a a matan	Disposition (Name of crematory or other place)	Date 20c	. Location - City or	Town, State
Ĕ	Pages Iment of I tent; If it		* 4 □ Donation 5 □ Other (Special	y) Cumbe		./4/06 C	umberland	l, MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent; If item 27 Is marked eny injury or other treumatic engo.		21. Signature of Funeral Service Lice			rdock-Durs		
	20200		Katherine)		m 21~N . ot enter the mode of dying, such as cardia	Second St.	, Oakland	Approximate
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	Physician /Medical		disease or condition resulting in death)	a. Ischemic Cardion Due to (or as a consequence of	· · · · · · · · · · · · · · · · · · ·			years
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Box	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
o.	that the de led by the a detached f	hysi	9 Unknown	9□ Unknown				
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Ö	w require been sig should b					1 🗆 Yes	2 No 3 Pro	obably 4 Unknown
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	: The	Con				perförmed 1 ☐ Yes 2 ☐	death?	2 □ No
Vita	icien: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	eath (Check only one)		
o	Phys this ral dir	To.	1 Yes 2 No 27. Manner of Death	1 Patient 2 ERVOut	patient 300A 40 Nursing	Home 5 Residence		cify)
Division of	Attending Physicien: r death. ector: After this certification the funeral director.	tion	1. ☐ Hatural 5 ☐ Pending investigation	(Month, Day Year) In	me of 28c. Injury at 28c/ Work? M 1 Yes 2 No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
N S	Attendi r death ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm	m, street, factory, office	28f. Location (Street	t and Number or Ru	ral Route Number,
ā	s afte	Certification:	4 1 Hollingide	building, etc. (Specify)		City or Town, St	ate)	
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate hy completely filled in by the funeral director, page.		29a. Certifier (Check only 2 Medical Exa	nysician: To the best of my knowledge, miner: On the basis of examination and	death occurred at the time, date and place	e, and due to the cause	a(s) and manner as	stated, to the cause(s)
	the H hin 24 the F nplete	Medicai	one)	and manner stated.				
	To wit	-	29b. Signature and title of certifier	1	29c. License number	290.	Date signed (Month	n, Day, rear) M î
•			30 Name and address of	completed region of death (from 22.) 5	DIJ 3 4	}	1117/	06
			Thomas G. Johnso	completed cause of death (Item 23a) (1	rth Street Oakland	1. MD 2155	0	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	LUI DELECT OAKTAIN	., LW 2133		
	Regist	rar	M O√ - 3	2008 Jane 1	South			

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iiii Ciiiioid Ce	inci		of Maryland /						200	0007
Amended	/	1- For State Registrar item #19a, 1. Decedent's Name (First, Middle, Las		e, cen	ilicate of t	Death 10	/31/06,	E.T, R		WEHD 3627
Physicia ledical Exami		JOHN CLIFFORD CEN	•					Month October 2	Day Year	3. Time of Death 1330 hrs
		4a. Facility Name (if not institution, giv Matapeake Pier	e street and number)			City, Town, or Stevensville	Location of Dea	ath	4c. County of Dea Queen Anne	
Funeral		5. Social Security Number 6. Se		(In yrs las	st birthday)	If Under 1 Yea			rth(MM/DD/YYYY) 9 E Fore	
Director		216 98 1606	Šм 2 F 25		Yrs	Months Day	s Hours M	March	20, 1981	CountryMaryland
any		10a State 10b County		10c. City, 7	Town or Location	า				10d Inside City Limits
viaryland 28a-f show	tor	Maryland Wicomico		Sali	sbury					1 X Yes 2 No
ne Many or 28a	Director	10e Street and Number 520 Alabama Ave.				10f. Zip Code		ł	Og Citizen of What Co	untry?
with the mas 23a be not	eral [11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	3. 13. Was	21801 Decedent of His	spanic Origin? (Specify Yes or No		erican Indian, Black,
er death	Funeral	1 X Never Married 2 Married 3 Widowed 4 Divorced		No		es $2 \times 10^{\circ}$ No	n, Mexican, Puer	to Rican, etc.)	White, etc.	
ours afi atural" vamine	d by	15. Decedent's Education (Specify or	or Dates:	oleted)	16a Decedent's	Usual Occupat	tion (Give kind o		Specify: Wh:	
36 in 72 h han "n fical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	1	auring mos Student	t of working life	. DO NOT use re	etired)		
d with	No.	17 Father's Name (First, Middle, Last)	_				18 Mother's Nar	ne (First, Middle, I	University Maiden Surname)	7
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed whin 72 hours after death with the Maryland Department of Health and Mental Hygiene in The Page 1 and Application of the Innovation: If tiem 27 is marked offer than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be	Richard Craig Cen	ter]	Patricia	a St	wain	
MD 2 nd 2 should alth and M m 27 is m aumatic e	T _o	19a Informant's Name/Relationship (T Dufendac Patricia Swain (M	h		1	Address (Stree Ley Stre		r Rural Route Nun	nber, City or Town, Sta	te, Zip Code)
re, N s I and f Healtl f item er trau	4	20a. Method of Disposition 1 Burial 2 X Cremation 3			ace of Disposition	on (Name of cer		Date Date	21811 20c. Location - City of	or Town, State
Baltimore, permit Pages I an Department of Hea Important: If iten		4 Donation 5 Other Specify:			e Henlop	oen Crem	natory1(Frankford,	
Ball permit Depart Impor		21 Sugnature of Funeral Service Liceo	usel.			me and Address		1(1 Homo 1	08 William Berlin, MD	
Physician			lications the caused t	he death. I	Do not enter the	mode of dying,	such as cardiac	or respiratory arm	est, shock, or heart	21811 Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a.	Drowning Due to (or as a consec	~						Death
+		Sequentially list conditions, b.								
	Examiner	if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consec	quence of):						
recuted 1 and - transit	Exal	events resulting in death) Last	Due to (or as a consec	quence or).						
क वं ७	Medical	UNPENDED	AMENDED							
8760, ifficate be ng physic is the bur	n/Me	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome	e of pregna		death 3	Ectopic pregi	nancy	23d Date of delive	ry Day Year
Box 68 re death certiff the attending red for use as:	/sician/	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at t	ime of dear	th Co	r (Specify)		Talloy	Month	Day
THE 2	P _P	Part II. Other significant conditions	9 Unknown	but not res	sulting in the unc	derlying cause g	liven in Part I	23e. Did to	bacco use contribute to	o the cause of death?
S Si es	ed by							1 Yes	s 2 🗸 No 3 Pro	obably 4 Unknown
of Vital Records, ing Physiciau: The law require this certificate has been shered director, page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 2 should the page 3 sho	Completed							24a Was autop		utopsy findings available completion of cause of
Vital Rec ysiciau: The his certificate director, page	Son	25. Was sass referred to modical				00 Di		1 🗸 Yes		′es 2 No
/ital	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	lospital: 1 Inpatien	nt 2 E	R/Outpatient :	T	of Death (Chec		Residence 6 V Other	er Scene
n of Vi ling Physi After this funeral dir		27. Manner of Death	28a Date of Injury Oct 21, 2006	y 2 ar)	28b. Time of Inju	iry 28c. Injur	ry at Work?	28d. Describe t	now injury occurred	
	catic	2 Accident Pending Investigation			0001 hrs		′es 2 ✔ No		, ,	
Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	3 ✓ Suicide 6 Could not determined	be	-	ne, ram, street,	ractory, office b	uliding, etc.	or Town, S	tate)	e, Stevensville, MD
Hos 24 h Fur								d due to the caus	e(s) and manner as sta	rted
To the within To the comple	Medical	one) 2 Medical Examiner 29th Signature and title of certifier	and manner stated	ination and	a/or investigation	29c. License		at the time, date a		
	_	Mounto A. C	Kull			O.C.N			29d Date signed (Miles) October 28, 200	
		30. Name and address of person who	completed cause of de	ath (Item 2	*					
ET 6			sistant Medical E				altimore, MD	21201		
St Regist	ate	31. Date filed (Month, Day, Year)	106 Segistrar's	s Signatur	Space	6.)				

Months

7. Age (In yrs. last birthday)

96

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

215-50-1364

Pearl M. Campaigne

4a. Facility Name (If not institution, give street and number)

CHESTERTOWN NURSING & REHABILITATION

1 □ M 2√2 F

Physician

/Medical

Examiner

Funeral

Director

36272

Rag. No.

Certificate of Death

CHESTERTOWN If Under 1 Year | If Under 24 Hrs.

Days

4b. City, Town, or Location of Death

Hours

2. Date of Death

October 26, 2006

3. Time of Death 07:24 a M

4c. County of Death

KENT

 Birthplace (State or Foreign Country) TT,

8. Date of Birth (Month, Day, Min 04/18/1910

> 10d. Inside City Limits 1 Yes 2 No

10g. Citizen of What Country?

USA

 Race - American Indian, Black, White, etc. Specify: WHITE

16b. Kind of Business/Industry

OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

113 LIME COURT, MILLINGTON, MD 21651

20c. Location - City or Town, State ARLINGTON, VA

FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA 130 SPEER ROAD, CHESTERTOWN, MD 21620

Approximate Interval Between Onset and Death

23d. Date of delivery Month Day

1 ☐ Yes 2 To No 3 ☐ Probably 4 ☐ Unknown

autopsy 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28l. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only

29c. License number

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 238

eted cause of death (Item/23a) (Type, Print) ann

31. Date liled (Month, Day, Year) 32. Registrar's Signature

Elsen &

DHMH 17 Rev 1/2001

Medica

State Registrar

Please Type or Print in Black Indelible Ink

wiichaei Claytor		State of Marylar 1- For State Registrar	nd / Depar <i>Cert</i>	rtment of tificate of	Health and Death	l Mental		200	0.00
Physici Medical Exam						-	2 Date of De		3. Time of Death
iviedicai Exam	ine	Michael Claytor 4a. Facility Name (if not institution, give street and num			<u>.</u>		Month Novemb	er 3, 2006 Year	1320 hrs
,		11702 Butlers Branch Road	ber)	4	b. City, Town, or L Clinton	ocation of De	ath	4c. County of Dea	
Funeral			Age (In yrs. las	st hirthday)	If Under 1 Year	If Under 24	llee 10 Dete - 15	Prince Georg	
Director	١.	578-78-5391 ₁ X _{M 2} F	50		Months Days		Min. Sont	3 I DE C	Birthplace (State or eign
		Usual Residence of Decedent		Yrs.	<u> </u>		Bept.	13, 1936 Was	eign Country) Shington.D.C
v any		10a State 10b. County	10c City, T	own or Location	on				10d. Inside City Limits
daryland 28a-f show 1 at once.	ō	Maryland Prince Georges	C1:	inton					1 Yes 2 No
Mary 28a- d at c	Director	10e Street and Number			10f. Zip Code			10g. Citizen of What Co	
ith the Maryland 23a or 28a-f sho notified at once.	Ö	11702 Butlers Branch Rd.			20735		Ī	United St	atac
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Force	lent Ever in U.S.		Decedent of Hispa	anic Origin? (Specify Yes or N	o- 14. Race - Ame	rican Indian, Black,
er dea			2 No		es, specify Cuban, N		rto Rican, etc.)	White, etc.	1
ırs aft ural"	þ	or Dates:	completed) 1		Yes 2 X No			Specify Bla	
72 hou	Completed	Elementary/Secondary (0-12) College (1-4		during mo	's Usual Occupation est of working life. D	n (Give kind o OO NOT use r	of work done etired)	16b. Kind of Business	/Industry
036 ithin ne ne r than	du	12	,	Corr	ectional	0664-			
D 21215-0036 should be filed within 72 l and Mental Hygiene 'is marked other than "r afte event, the Medical E		17. Father's Name (First, Middle, Last)		- 0011				Governme Maiden Surname)	nt
2121 uld be fil Mental I marked	Be	Jack Claytor			İ	Mary	Crawford		
D 2 should and M is m aftic e	ဥ	19a. Informant's Name/Relationship (Type, Print)				and Number o	r Rural Route Nu	mber, City or Town, State	
ore, MD 2121 ss I and 2 should be find the find the find the should be find the find		Paula Claytor/Wife 20a Method of Disposition	201 01	1004	Montezuma	a Dr.	Ft. Wash	ington, Md.	20744
Baltimore, MD 2121 bernit Pages I and 2 should be fi Department of Health and Mental I important: If item 27 is marked nijury or other traumatic event,		1 X Burial 2 Cremation 3 Removal from	State Cre		ion (Name of ceme er place) Veterans	tery,	Date	20c Location - City or	Town, State
tim t Paj tmeni rtant y or o		4 Donation 5 Other Specify	_ Mar	yland	Veterans	111,	/13/2006	Cheltenha	m, Md.
Baltimo permit Page Department o Important: injury or oth	T)	21. Signature of Funeral Service (Lensee		22. Na	me and Address of	Facility	o Funon	-1 17 - 7	
Physician	-	23a PTI I. Enter the dis Jise, or comply ations that caus failure. List only Jise cause on each line	ed the eath D	1 5.	538 Marib	oro P	ke/Fore	al Homes, P stville, Md	:A·20747
/Medical		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			mode or dying, su	cn as cardiac	or respiratory are	est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a co		sis					Death
and a		Sequentially list conditions, b	1004001100 01).						
	iner	if any, leading to immediate Due to (or as a coll cause Enter Underlying Cause	nsequence of):						
	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a continuous contin	nsequence of).						
		d.	,						
60, ate be executed hysician and te burial - transi	Medical	X UNPENDED X AMENDED #1	222 27 -	N/IC C	10/7/0				
		IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the	ome of pregnan	enyk, ge icy	362 <u>.</u> 12/7/00	5 TT		23d Date of delivery	,
Sox 687 leath certific attending of	ician/	past 12 months?	at time of death	2 Fetal	death 3	Ectopic pregr	ancy		Day Year
Box 687 e death certific the attending p	10	1 Yes 2 No 9 Unknown 9 Unknown		5 Othe	r (Specify)				
P.O. I s that the gned by the e detacher	/ Phys	Part II. Other significant conditions contributing to de	ath but not resul	Iting in the unc	derlying cause give	n in Part I.	23e. Did to	bacco use contribute to	the cause of death?
0 .= 6	a b							2 ✓ No 3 Prob	
of Vital Records, ng Physician: The law requir wfter this certificate has been s meral director, page 2 should I	Completed						24a. Was		topsy findings available
tal Reco	틹						autop perfor	sy prior to c	ompletion of cause of
an: T		25. Was case referred to medical			26 Place of I	Death (Check	1 Yes	2 No 1 Ye	s 2 No
Vita hysicia this ca	o Be	examiner? 1 ✓ Yes 2 No Hospital 1 Inpat	tient 2 ER	/Outpatient 3		00		Residence 6 🗸 Other	
n of ing Pl	-	27. Manner of Death 28a Date of Ir	ijury 28	b. Time of Inju	-	L		ow injury occurred	Scene
	읉	1 X Natural 5 Pending (Month, Day 2 Accident Investigation	, reary		1 Yes	2 No		, ,	
Division spiral or Attendir ours after death. teral Director: A	Certification:	3 Suicide 6 Could not be 28e. Place of	Injury - At home	, farm, street,	factory, office buildi	ing, etc.	28f. Location (S	treet and Number or Rur	al Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director	اق ا	4 Honielde determined (Specify)					or Town, St	ate)	
To the Hos within 24 h To the Fur	edical	29a Certifier (Check only one) Certifying Physician: To the best of the one one of Madical Examination the house of the one of the o	ny knowledge, d	death occurred	at the time, date a	and place, and	due to the cause	e(s) and manner as starte	ed
To the within To the comple	Med.	one) 2 Medical Examiner: On the basis of ex and manner stated 29b Signature and title of certifier	amination and/o	r investigation	i, in my opinion, dea	ath occurred	at the time, date a	and place, and due to the	cause(s)
	-	Organization and title of certifier			29c. License nu			29d. Date signed (Mon	th, Day, Year)
		Melyme Me Mull			O.C.M.E			November 4, 200	6
		 Name and ddress of person who completed cause of Margarita Korell MD. Assistant Medica 		•	- 01 - 1 2 - 1				
Sta	te				n Street, Baltir	nore, MD	21201		
Registr	-	NOV 0 8 2006 Bacon	B. A.	feet.					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** L. COLLINS 5:45 PM NOV 2006 2, /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Gilchrist Hospice Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 19, 5. Social Security Number 421–46–4182 9. Birthplace (State or Foreign **Funeral** 1941 Birmingham, AL 1 □ M 2XXF Months Days Hours Jan. Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla carment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Glen Rock PA York 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 28 Hayward Heights 17327 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2€ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 🙀 No Specify: ģ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Computer Programer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carolyn Scott Gerald A. Collins Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 28 Hayward Heights, Glen Rock, PA 17327 19a. Informant's Name/Relationship (Type. Print) Robert L. Collins Son altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation M Removal from State Nov.8,2006 Birmingham, AL 35211 Elmwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Geiple Funeral Home, Inc. Selva 53 Main St. Glen Rock, PA 17327 #CC0265 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ear SQUAMOUS /Medical Due to as a consequence of): Examiner Sequentially list conditions, I any La Ing to Imm data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): physician Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 Tyes 2 ∏ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဥ 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

Box 68760. P.O. Division or Vital Records, To the Hospital or Attending Physician: funeral director, After this within 24 hours after death.

To the Funeral Director: of completely filled in by the f

Certification:

27. Manner of Death

29a. Certifier

1 Natural 5 Pending 2 Accident 3 ☐ Suicide 4 Homicide

investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Płace of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? Injury

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

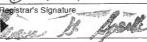
les St. Balto Md 21204

November 3, 2006

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who compléted cause of death (Item 23a) (Type, Print)
W. A. R. Ley G. B. M. C. 6701 N. Cle

Year)-31. Date filed (Month, Day, 32. Registrar's Signature



0

State Registrar

Dunn, William

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 115

36276

			1 - State Registrar		Cer	tificate of	Death		Reg. No.	00	00210
			1. Decedent's Name (First, Middle, Las	t)				2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medio		William E	arl Dunn				October	010	006	1630 M
	Examin		4a. Facility Name (If not institution, give	street and number)		age of	r Location of Death	1		y of Death	
				ospital		Eas				lbot	
	Funeral		5. Social Security Number 6. Se	THE OFF	yrs. last birthday) _ 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	_ 8. Date of Bir (Month, Da October	th ay, Year)	9. Birthp	place (State or Foreign htry)
	Director		413-52-9383 Usual Residence of Decedent		68 Yrs.			October	17, 1938	Vir	ginia
	and w		10a. State 10b. County	10	c. City, Town or Loc	ation				1	IOd. Inside City Limits
	Mary	ō	Maryland Carol	ine	Ridgely						1 □ Yes 2 🖰 No
	289	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	72 hours after death with the Maryland natural', or Itema 23a or 28a-f ehow lical Examinat must be notified at	<u></u>	11579 Ridgely Roa	d		21629		L	Inited S	tates	s of Americ
	death	Funeral	11. Marital Status	12. Was Decedent Ever	r in U.S. 13. Y	Vas Decedent of H	dispanic Origin? (S an, Mexican, Puert	pecify Yes or No	o- 14. Ra	ce - Americ	
9	after or its		1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ⊠Yes 2 □ No	1920-			o Rican, etc.)		ick, White,	etc.
03	reif, c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1959	☐ Yes 2☐ No	Specify:		Speci		casian
21215-0036	s 1 and 2 should be filed within 72 hours after death w Heelth and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23e other traumatic event, the Medical Examinat matal	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give I	ent's Usual Occup	during most of wor	kina	16b. Kind of E	Jusiness/In	dustry
21	within ene. then "	d F	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired				0.1	4
2	filed with Hygiene. other ther	ဒိ	12 HS Grad		Dies	el Mecha				mobil	e
B	be fill	Be	17. Father's Name (First, Middle, Last)	4 2			18. Mother's Nan				
yla	should be filed within nd Mental Hygiene marked other then umatic event, the Mi	2	Willie Ear					Violet			
Maryland	2 sho and is my reum		19a. Informant's Name/Relationship (7			-	and Number or Au Lidgely, 1			, State, Zip	Code)
	s 1 and if Heelth item 27 other 1		Rebecca L. Dunn 20a. Method of Disposition	Wife	20b. Place of Dispos	A AMERICAN CANADA STATE OF THE STATE OF	myery,	Date	20c. Location	Cibe on Te	State
Ö	a 0		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crem	atory or other place					
ţ	artmen ortant: injury		4 □ Donation 5 □ Other (Specify		Capitol		,		Dover,	Delau	vare
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lieber	loor	Mo	Name and Addre	ess of Eacility	, P.A.			
	402 60		- January 11:		12	South S	econd St	reet, De	enton, P	laryfo	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.	death. Do not ente	er the mode of dylr	ng, such as cardiad	or respiratory a	irrest,		Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition resulting in death)	a Pulmono		(0515					
1	/Medical Examiner		resuming in dealing	Due to (or as a co	ensequence of):	. \ -					
	ZXX		Sequentially list conditions.	b. Yodrotis	2 prelin	china					
	sit s	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	insequence or):	1 1					
	and -tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a co	Dall Cel	u lung	g can	ier			
60,	be ey icien buria		Q.	300 10 (0. 20 2 00	moduomoo on.	\mathcal{O}	/				
68760	certificate be executed iding physicien and ise as the burial-transit	VMedical	•	d							
χ 6	certific Iding pl	/Me	IF FEMALE:	23c. If yes, outcome of p	regnancy				201.0		
Bo			in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	<i>y</i>			ate of delive onth	ory Day Year
o.	The law requires that the death sie has been signed by the atte bege 2 should be detached for i	Physicia	1 Yes 2 No 9 Unknown	9□ Unknown	501 368(1) 5	Other (specify)					
Δ.	that ed by deta	급	Part II. Other significant conditions co	entributing to death but no	ot resulting in the un	derlying cause giv	en in Part I.	23e. Did 1	tobacco use con	tribute to th	he cause of death?
sp.	sign d be	d by	connective	MART &	Sylve	`		102	765 2 □ No	3 🗆 Prob	pably 4 Unknown
Ö	w requir been si should i	ete	Atrial C-1:16	tion				24a. Was	an 24h	Ware auto	ney findings available
Re	has ge 2	Completed	1711101 0 100110	(1(0,1				auto		prior to cor death?	psy findings available mpletion of cause of
of Vital Records,		e C	25. Was case referred to medical					1 ☐ Yes	2 No	1 🗆 Yes	2 No
₹	Physician: r this certifica ral director, i	8	examiner?	Hospital: Inpatient	2 ER/Outpatient	20 DOA Oth	26. Place of Dea	- 11			
	₽ = ₽	. To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur		ome 5 Resi	how injury occur		y)
9	를 근존 j	ig ig	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Injury		rk? Yes 2.⊡No				
Division	l or Attending efter death. Director: After I in by the fune	fica	3 Suicide 6 Could not be	28e. Place of injury	At home, farm, stre	et, factory, office				ber or Rura	al Route Number.
S	i i te o	Certification:	4 Homicide	building, etc. (S	Specify)			City or To	wn, State)		
	ospital or A hours efter uneral Dire		29a. Certifier 1 Certifying Phy	ysician: To the best of m	y knowledge, death	occurred at the tir	me, date and place	, and due to the	cause(s) and m	anner as s	tated.
	To the Hospital or Attenwihin 24 hours efter death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exam	iner: On the basis of exa and manner stated.	amination and/or inv	estigation, in my o	pinion, death occu	rred at the time,	date and place,	and due to	the cause(s)
	To th within To th comp	ž	29b. Signature and title of certifier	1		29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)
			Hill-	inal in	2	Do	25970	62	11)	OYC	06
			30. Name and address of person who d	completed cause of death	(Item 3a) (Type, F	Print)					
			Haider Som	of IND		216	00				
4	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	paskes					
	- (-) a [[-]]	20									

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nø. 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** Month Year John 15 AM Charles /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ARFOR If Under 2 Hrs. If Under 1 Year 8. Date of Birth Month, Day, Year) 12/25/1919 9. Birthplace (State or Foreign Country), Slovakia 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 X M 2 □ F 063-16-8744 Director 86 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show other treumetic event, the Medical Example: mast be mutified at Director 1 Yes 2 □ No MD Harford Aberdeen or 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 398 Union Street or itams 23e 21001 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:1941-45 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Manufacturing Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental f Health and Menta Martin Duda Marion UNK ဂ္ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Fothergill (Guardian) 398 Union St., Aberdeen, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent; if ite any injury or ot once. Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gdns. 11/14/06 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name, and Address of Facility
Tarring-Cargo Funeral Home, P.
Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Suspecte Pnysician /Medical Due to vr as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a nonsequence of: Physician/Medical Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 🗆 N Certification: To 2 ER/Outpatient 3 DOA 4 ursing Home 5 Residence 6 Other (Specify) funeral 27. Manne Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After (Month, Day Year) 5 Pendina atural 1 atural 2 Accident death. investigation 1 🗌 Yes 2 No filled in by the f 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a To the Funeral I

Division of Vital Records,

E

State

Medical

30. Name and address of person Year 6 2006

who completed cause ath (Item 23a) (Type, Print) 32. egistrar's Signatu

Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifier

			For State Registrar		State of M	larylan	d / Depa	artmen rtificat	t of H e of L	ealth a	and M	ental Hy	giene Reg. No		36278
	DI		Decedent's Nar	me (First, Middle,	Last)							2. Date of De	aath Da	ıy Year	3. Time of Death
	Physici: /Medic		Lottie	Eli	zabeth	Di	az					Novemb	er 3	3 2006	9:15 A M
	Examin		4a. Facility Name	(If not institution,	give street and number	•)		4b. City,	Town, or	Location o	f Death		40	. County of Dea	ath
			Moran Ma	anor Nurs	ing Home			West	ernp	ort			A	Allegany	7
	Funeral		5. Social Security	Number 6		ge (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi	th Year	9. Bi	rthplace (State or Foreign country)
	Director		216-09-7	7657	1□M 2\ F	9	2 Yrs.	WORKING	Days	riours		March		14 Mai	ryland
	P .		Usual Residence			10- 00	7								Land to the Otto Links
	aryla show	_	10a. State	10b. County		TOC. CIT	y, Town or Lo	cation							10d. Inside City Limits
	W L	cto	MD	Allegan	У	L	uke								1 Yes 2 No
	or 28	Director	10e. Street and N					10f. Zip					-	tizen of What C	-
	23e	al	329 Fa	irview S	treet			21	540				Unit	ed Stat	es
	ems	Funeral	11. Marital Status		12. Was Deceden Armed Forces			Was Deced	dent of Hi	spanic Orig	gin? (Spe	cify Yes or Ne Rican, etc.)	0-	14. Race - Am Black, Wh	
٥	or it			rried 2 Marrie	d 1 □ Yes 2√F If Yes, Give 1	No No		1 🗆 Yes	_	Specify:				Specify: _	
Š	hours after death with the Maryland tural; or Items 23e or 28e-f show al Examinat must be notified at	d by	3 XWidowed	4 Divorced	Year or Dates:	:							,	M. M	Mite
215-0036	72 h	Completed	(Spe	 15. Decedent's ecify only highest 			16a. Deced	kind of wo	rk done d	uring most	of working	ng	16b. K	(ind of Business	s/Industry
2	Athin Pan Pan	dμ	Elementary/Sec	, , ,	College (1-4or	5+)		oo vot u: Omema	,	,				Home	
7	led v tygie her t			NOWN e (First, Middle, La			П	Juena	ret.	40.44-45	d- No-	(F)			
	tal tal	Be										(First, Middle		n Surname)	
<u>\ \</u>	ould Mer warks	ဥ		er Mille								Mille			
Maryland	2 sh and Is m			Name/Relationship				-						or Town, State,	Zip Code)
e .	and lealth m 27 her t		Nancy Fo		augnter	205 5				Dr.,		y New 1			7
0	Tiof H		20a. Method of Di		Removal from State	C	lace of Dispo	natory or o	ther place					ocation - City o	
Baitimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Indepartment of Health and Mental Hygiene. Indepartment of Health and Mental Hygiene. any injury or other treumatic event, the Medical Examinat must be notified at once.		* 4 Donation	5 ☐ Other (Spe	cify)	Ph	ilos Ce	emete:	ry	N	ov 5,	,2006	Wes:	ternpor	t,Md
ğ	epart epart port ny in		21. Signature of I	Funeral Service Li	censee	1	22 Pc	. Name an	d Addres	s of Facility	y mo. 11	11 Ch	ا جاجم	αĻ	
ш	20 E a a		7	way	nella		We	ester	port	Md.	21562	11 Chui	ren a	St	
			23a. Part1. Enter shock, or he	r the disease, or co eart failure. List or	omplications that cause nly one cause on each	d the death line.	h. Do not ent	er the mod	e of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause disease or condit		En	det	all	as	22/h	lim	ers	2	sea	4	Onset and Death
	/Medical		resulting in death	1)	Due to (or a	s a conseq	uence of):		7				9		
	Examiner		Sequentially list of	conditions	b										
	D =	ner	Sequentially list of if any, leading to cause. Enter Und	immediate deriving	Due to (or a	s a conseq	uence of):								
	cuter	Examine	Cause (Disease of that initiated even	or injurý nts	c										
Ć	an al rial-t		resulting in death) Last	Due to (or a	s a conseq	uence of):								
08/20	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	icai			d										
٥	ng ph as t	Physician/Med	IF FEMALE:												1
ŏ	th ce endii r use	Jug	23b. Was decede		23c. If yes, outcom 1 ☐ Live birth			Ectopic pr	egnancy					23d. Date of de	
מ	dea deatl	Sici	in the past 1	2 No	4□Pregnant a 9□Unknown			Other (sp						Month	Day Year
5	at the	چ	9 □ Unknow												
, S	w requires that the death certifica been signed by the attending pt should be detached for use as th	ğ	Part II. Other sign	nificent condition	s contributing to death	but not resi	ulting in the u	nderlying c	ause give	n in Part I.					to the cause of death?
coras,	aquir en si ould i											1 🗆	Yes 2	□No 3□P	robably 4 Unknown
သ	aw re	Plet										24a. Was		24b. Were a	utopsy findings available completion of cause of
Ĕ	rsician: The law s certificate has b lirector, page 2 s	Completed				-						auto perfo	ormed? 2 √√√√	death?	
VII TA	an: tifica tor, p	0	25. Was case refe	erred to medical						26. Place	of Death	(Check only		10.10	20110
>	ysici s cer direc	To B	examiner?	No	Hospital: 1 ☐ Inpat	ient 2	ER/Outpatien	t 3 DC	A Othe	-				6 ☐Other (Spe	ecify)
5	g Ph er th		27. Manner of De		28a. Date of Inj (Month, D	ury	28b. Time of	2	Bc. Injury Work	at		8d. Describe			
0	ath. r: Aft e fun	atio	2 Accident	5 🗌 Pending investiga		ay roar/	injury	м		es 2□N	No				
VISION	Atta rr deg ecto by th	ertification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	288. Place of It	njury - At ho	me, farm, str	eet, factory	, office	1	2				lural Route Number,
5	alor safte al Dir	Cert	4 Nothicide	•	duliding, e	itc. (Specify	*/)					City or To	wn, State	9)	
	spit hours iners y fille		29a. Certifier	Certifying	Physician: To the bes	t of my kno	wledge, death	occurred	at the tim	e, date and	d place, a	nd due to the	cause(s) and manner a	s stated.
	10 Hc	edical	(Check only one)	Z Medical Ex	aminer: On the basis and manner s	of examina tated.	tion and/or inv	estigation,	in my op	inion, deat	h occurre	d at the time,	date and	d place, and du	e to the cause(s)
	To the Hospital or Attending Physician: The within 24 Hours atter death. To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page	ž	29b. Signature an	nd title of certifier				290	. License	number			29d. Da	te signed (Mon	th, Day, Year)
				1/	n) /	/			20	212	1020			11/2/	2006
			30. Name and ad	dress of person wi	no completed cause of	death (Item	23a) (Type,	Print)	V	<u>~</u>	7			1101	1006
									532						
	` Sta	ite	31. Date filed (Mo	onth, Day, Year)	Broadway, 32. Regist	rar's Signa	ture	MC -							
	Registr			NOV 3	2006	byve	Di A	month	7						

_			1 - For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment of H	lealth and Death	n'	eg. 140.	06 36279
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dear		3. Time of Death
	/Medic			ALTON		I =				2006 7:50PM
	Examin	er	4a. Facilis National Information give	Medical	Center	4b. City, Town, or	r Location of Deat TOM	n Ison	4c. County of	Baltimore
	Funeral		Social Security Number 6. Se	TM 200 = -	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	Year)	Birthplace (State or Foreign Country)
	Director		213 14 0100	X ^{M 2□ F} 86	Yrs.			Feb. 6,	* * * * *	Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Maryi	ŏ	Maryland Worceste	r 0	noon Dina					1√2 Yes 2 □ No
	28s-	Director	10e. Street and Number	<u>.</u>	cean Pine	10f. Zip Code		1	0g. Citizen of W	hat Country?
	3a or	0	45 Abbeyshire Lan	е		21811			U.S.A.	
	death	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No-	14. Race	- American Indian, White, etc.
9	d within 72 hours after death with the Maryland jane, than "naturel", or Items 23s or 28s-f ehow the Madical Examinar must be maillist a	교	1 Never Married 2 Married	1 1 Yes 2 □ No		1 ☐ Yes 2 ☑ No	Specify:	to ritoari, etc.)	Specify:	
21215-0036	urel'.	d by	3 X Widowed 4 □ Divorced	If Yes, Give WW Year or Dates: WW						MILLE
5	"nati	Completed	15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo	rking	16b. Kind of Bus	siness/Industry
12	filed within Hygiene. ther than "ther then "int, the war.	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	Firen		-/		Fire De	partment
	흥분하다	0	17. Father's Name (First, Middle, Last)		TITE	ian	18. Mother's Na	me (First, Middle, I		
lan		To B	Edward Dalton				Catheri	ne Ostend	lorf	
Maryland	s 1 end 2 should Heelth and Men Item 27 is marke other treumatic	-	19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailie	ng Address (Street	and Number or Ri	ural Route Number	, City or Town, S	State, Zip Code)
	1 end 2 Heelth em 27 l		Michael Dalton			Holly Bea		Essex, M		
ore	80		20a. Method of Disposition 1 □ZBurial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place	ce)	Date	20c. Location - (City or Town, State
Ë	ment of tent: If Its		4 ☐Donation 5 ☐ Other (Specify)		s Churchy		3/06 I	erlin,	Maryland
Baltimore,	permit. Pag Department Importent: It any Injury o		21. Signature of Fun all Service Licens	988		2. Name and Addres		10	8 Willi	am St.
	403 4 G		23a. Part1. Enter the disease or comp	whan		e Burbage				D 21811 Approximate
	/Medical Examiner	Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Saluer tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	aRÉSFIRI Due to (or as a co	onsequence of):	AILURE JCTIVE F	PULMONA	RY DISE	ASE	Interval Between Onset and Death
68760,	icate be executed physicien and s the burial-transit	ai Ex	resulting in death) Last	Due to (or as a co	onsequence of):					
687	ificate g phy: as the	edical		u .						
P.O. Box	it the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date Mon	of delivery th Day Year
Records, P	signed signed d be de	ρ	Part II. Other significant conditions on CONGESTIVE HEART F		ot resulting in the u	nderlying cause giv	en in Part I.		/	bute to the cause of death? 3 Probably 4 Unknown
8	s been shoul	Completed	RENAL FAILURE					24a. Was a	n 24b. W	ere autopsy findings available
Be	The lavate hes	E O	KENAB FAILURE					autops	ried? pr	for to completion of cause of eath?
		0	25. Was case referred to medical				26. Place of De	1 ☐ Yes : ath Check only on		Yes 2 No
<u> </u>	Physician: this cartificanal director,	To B	examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 1/ Inpatient	2 ER/Outpatier	nt 3 DOA Oth	00	Home 5 ☐ Reside		r (Specify)
	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c. Injun Wor	y at k?	28d. Describe ho	w injury occurre	od
Siol	Attending in death.	atic	2 Accident investigation				Yes 2 □No			
Division	in the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5		reet, factory, office		28f. Location (Si City or Town	reet and Numbe n, State)	r or Rural Route Number,
	To the Hospital of within 24 hours a To the Funeral D completely filled in the Funeral	Medical	29a. Certifier 1 Certifying Phyone) 1 Medical Exam	vsician: To the best of m iner: On the basis of ex and manner stated	amination and/or in	h occurred at the tin vestigation, in my o	me, date and place pinion, death occ	e, and due to the curred at the time, d	ause(s) and mar ate and place, a	nner as stated. nd due to the cause(s)
	To t To ti	Σ	29b. Signature and title of certifier	11-11-	as A	29c. Licens			1 0	(Month, Day, Year)
			· A. J.	Helou	101.1	DØØ	117695		20106	er 29,2006
£ 1	1+61		30. Name and address of person who o				, pro. op 1 1 pm	pp 2004 1 2 2004 200 4		
21			ABDALLAH J. HE 31. Date filed (Month, Day, Year)	LOU, M.D.	Signaturo		KIVE, "	rowson,	MARYLA	ND 21204
	Sta	ite	00T 9 1 20		K ho	adil				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 10 Rya1 Davis /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Vicomica Keninswa Kegionas Medicas Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days 1⊠M 2□F Director July 10,1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show la or 28a-f sh t be notified a 1 Yes 2 No Director MD Wicomico Willards 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with is 1 and 2 should be filed within 72 hours after death wi of Health and Mental Hyglene. item 27 is marked other than "natural", or Items 23a other traumatic event, the Medical Examiner must b. 36511 Old Ocean City Road 21874 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 Ž No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in ment of Health and Mental ဥ Davis Beauchamp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 234 Creekside Drive Judy Wells- daughter Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/30/2006 Willards, Maryland Dennis Cemetery 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee 705 E Main Street Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complice shock, or heart failure. List only and ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) YPOVOLEMIC **Physician** 3 hours /Medical Due to (or as a consequence of) Examiner EEDING Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the at d be detached for ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by FOR COLON 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DEVERE 24a. Was an s certificate has I lirector, page 2 s autopsy performed? Yes 2 No CORONARY ARTERY 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? director. To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1X Natural 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cepti 41567 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 145 E. CARROLL ST SALISBURY MD NICHOLASJ DUDAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ODIGINIAL

	1 - For State Registrar	State of Marylar		artment of H		and Mer		ne 0 (36281		
Physiciar /Medica	Hai vey Ci	ast) arles Duncanson	n				Date of Death Month OCTOBER	Day 18 2	3. Time of Death 9:20 P. M		
Examine	An Challes Manney When Advantages about			4b. City, Town, or P		of Death		4c. County	of Death CECIL		
Funeral Director	5. Social Security Number 107-22-8371	Sex 7. Age (In yrs. 1. 1 M 2 □ F 77	last birthday) Yrs.	If Under 1 Year Months Days	If Under: Hours	Min.	Date of Birth (Month, Day, Y ar. 9,	1929	Birthplace (State or Foreign Country) New York		
be filed within 72 hours after death verilla Hygiene dother than "naturel", or items 23s event. I're Modical Examinat must	10e. Street and Number 3700 North Cap 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest status) 17. Father's Name (First, Middle, La	hington itol St., NW 12. Was Decedent Ever in the Armed Forces? 1 Syes 2 No If Yes, Give Year or Dates: 1948 Education Irrade completed) College (1-4or 5+) unknown st) Inknown	J.S. 13. 13. 14. 16. Dece (Give life. 1	20011 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:					OWN City or Town, State, Zip Code) 21902		
permit. Pages 1 an Department of Heal Important: If Item 3 eny injury or other once.	20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or or	Permoval from State Qua	ntico Nat	sition (Name of natory or other place tional Ceme Name and Addrese A. Paterryville erryville	tery ss of Facilit terso e, Mar	on & S cyland	/06 Ti on Fune: 21903	ral Hon -0766	Approximate		
Physician /Medical Examiner sthe parial-transit		a. SEPSIS Due to (or as a consection of the con	AILURE						Interval Between Onset and Death UNKNOWN		
The law requires that the death certific tale has been signed by the attending page 2 should be detached for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)				23d. Date Mon	a of delivery th Day Year		
8 6 8	Part ii. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.				bute to the cause of death?		
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gr ffer l	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could no	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1	er: 4 □ Nu ⁄at	rsing Home 28d	5 Residence Describe how Location (Street	injury occurre			
n 24 houn n 24 houn he Funer pletely fill	29a. Certifier	building, etc. (Spec Physician: To the best of my kn aminar: On the basis of examin and manner stated.	ify) owledge, death	n occurred at the tin vestigation, in my o	pinion, dea	d place, and	City or Town, S due to the causat the time, date	State) Se(s) and mar	nner as stated. nd due to the cause(s)		
To T vith To C om	29b. Signature and title of certifier 30. Name and address of person with				D5273		O	CTOBER	(Month, Day, Year) 1.8 ; 2006		
State Registra	SURESH SHANDELYA 31. Date filed (Month, Day, Year) NOV 0	32. Registrar's Sign			RE SYS	STEM,	PERRY P	OINT, I	MD 21902		

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar 36282 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Dolores Mae DeOrsey 4:23 A M 26, October 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Nursing and Rehab. Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 212 F 188-20-2477 Yrs. Director 79 May 21, 1927 Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examiner must be notified at Maryland Anne Arundel 1 Yes 2 □ No Annapolis Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 312 Burnside Street 21403 U.S.A. items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 2 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Psychiatric Nurse 5+ Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f Clyde Prosser Is marked Barbara McCaffrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum once. Robert DeOrsey/son 320 Oak Way Drive South Haven, Michigan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 10/28/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature—Fineral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mosch **Physician** disease or condition resulting in death) PAVS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached o. 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 Yes 2 No of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 1 Yes 2₽No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Division 1 - Hatural 5 Pending investigation within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ŏ 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) rson who completed cause of death (Item 23a) (Type, Print) Name and address of & VOREMD eensburg 31. Date filed (Month, Day, Year) State OCT 2 7 2006 Registrar

•	V.		1 - For admendment item#4	State of Maryla , QACHD, 11/8	nd / Depa /06 tw	artment rtificate	of H	ealth a Death				2006	362	83
	Physici	an	Decedent's Name (First, Middle, Last)	_						Date of Dea Month	Day	Year	3. Time of I	
	/Medic	al	4a. Facility Name (If not institution, give stre			4h City 1	Town or	Location o		OCTOBER		2006 County of Deal	9:10	Ам
	Examin	er	HEARTLAND HOUSE	et and number)		GRASO			Di Dealli		Q	ueen Ann	ne's	
	Funeral	-	5. Social Security Number 6. Sex		. last birthday)	If Under	1 Year	If Under :	24 Hrs.	8. Date of Birth (Month, Day		9. Birt	thplace (State or ountry)	Foreign
	Director		5/9-01-2204	89	Yrs.	Months	Day <i>s</i>	Hours		02/26/1		DC	ountry)	
	and w		Usuel Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation							10d. Inside Cit	v Limits
	Mary -f ehc	tor	MD PRINCE GEO	RCFS DIG	STRICT	HETCH	rc						1 □ Yes	2 X No
	h the	Irec	10e. Street and Number	KOLD DIE	JIRLOI	10f. Zip					10g. Citize	en of What Co	ountry?	
	23a c	ralD	6524 KENOVA ST.			2074	47				USA			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: if item 27 is marked other than "natural, or iteme 23e or 28e-f ehow any follury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 12 1 ☐ Never Married 2 ∰ Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent Ever in a Armed Forces? 1 ☐ Yes 2 N No If Yes, Give Year or Dates:		Was Deced If Yes, spec 1 ☐ Yes 2	fy Cubai	spanic Orig n, Mexican Specify:	i, Puerto F	city Yes or No- Rican, etc.)		4. Race - Ame Black, Whit	e, etc.	
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Maryland	should ind Men ind marke	ဥ	TURNER ASHBY DULANE 19a. Informant's Name/Relationship (Type		19b. Mailir	na Address				TTE BAR Route Number		Town State 2	Zin Codel	
∑	and 2 salth ar n 27 is		BARBARA SPEAKER / DA	·	1					HESTER,			Lip Gode)	
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Ē	Pages nent of ant: if its ary or o		1 XBurial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)		DAR HIL	_	_ •	1	1/03/	2006	SIITTI	AND, M	m	
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>	Physician /Medical Examiner		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	caused the decause of the decause of each line. Let use of each line. Due to (or as a conse	et cale	er the mode	e ol dying	allul	cardiac or	respiratory arr	rest,		Approximate Interval Betw Onset and D	reen
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Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	atlon; To	27. Manner of Death 1 Death 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Bc. Injury Work	4 🗀 1401	2	ne 5 ☐ Resid 8d. Describe h			city) \$551576	pune)
<u>×</u>	ital or Att ins after d rai Direct led in by 1	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)					City or Tow	n, State)		ural Route Numb	er,
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•	To To	~	Speed IV- 00	rlhersen			License 27		5			31-06		
			30. Name and address of person who com TOBL W. W. LKER. 31. Date filed (Month, Day, Year)	oleted cause of death (Ite	200	Print) 1 M6	Dic	x/C	ENT	se Rd.	GRA	isonu,	116 M.	0.
	Sta Registr		NOV 1 200		H. A.	melle							/	

06-08100	
Sylvester	Douglas

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

, ,		cate of Death	Reg. No.	10 2000
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Sylvester Douglas		2. Date of Death Month Day Year	Time of Death C 2055 hrs
Miedical Examiner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	October 27, 2006 th 4c. County of Dea	
	301 Nalley Road	Landover	Prince Georg	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last bit 216–86–5960 1 M 2 F 41	rthday) If Under 1 Year If Under 24Hr Months Days Hours Mit	— 1 ₅₀ ,	Birthplace (State or eign Country) Maryland
àue à	Usual Residence of Decedent 10a State	n or Location		10d. Inside City Limits
faryland 188 - Fshow 1 at once.	Maryland Prince George Landov	ver		1 Yes 2 No
th the Maryland 23a or 28a-f shu notified at once	10e Street and Number 301 Nalley Road	10f. Zip Code 20785	10g. Citizen of What Co United Sta	,
ter death with ", or items 23 er must be no / Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Sive Year	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto Yes 2 X No specify:	o Rican, etc.) White, etc	erican Indian, 8lack, 31ack
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "matural", or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) 16a Elementary/Secondary (0-12) College (1-4 or 5+) 12	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ref	work done 16b. Kind of Busines:	
11215-0036 Id be filed within 72 Artental Hygiene event, the Medical Be Comple	17 Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
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	Teri Douglas/Wife	Bb. Mailing Address (Street and Number or 301 Nalley Rd.; Land	over, MD. 20785	te, Ztp Code)
more, M Pages 1 and 2 tent of Health ant: If item 2 or other traum	1 Burial 2 Cremation 3 Removal from State crema	of Disposition (Name of cemetery, story or other place)	Date 20c. Location - City of	
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Balt permit Depart Import injury	ava Sollaholl	5 F	ope Funeral Homes 538 Marlboro Pike orestville, Md. 2	0747
Physician	23a. Part I. Enter the dilear or complictions that if used the deal of Doin failure. List only one cause on earline.	ot enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
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Diversal meral L	4 Homicide determined (Specify) residence		or Town. State) 301 Malle Landover, MD	
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certifi completely filled in by the funeral director. Medical Certification: To Be C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or i and manner stated	investigation, in my opinion, death occurred a		
2	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d Date signed (Mo	
00	30 Name/and address of person who completed cause of death (Item 23a)		7 5.500, 20, 200	-
MC	Melissa Brassell, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD	21201	
State Registrar	31. Date filed (Month, Day, Year) NOV 08 2006	ed		

			For State Registrar	State of Mar	yland / De	epartment of learning of learning of the contract of the contr	Health and M Death		giene 2 Reg. No.	2006	36285	
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death	
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	Examin	er	Upper Chesapeake			Bel A				Harford		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bin (Month, Da	th ly, Year)	9. Birthp Coun	lace (State or Foreign	
`	Director		213-58-1575 Usual Residence of Decedent	55	Yr	S.		FEB 10	, 195	1 Mai	ryland	
	laryland •how		10a. State 10b. County	1	0c. City, Town o	or Location				1	0d. Inside City Limits	
	Ba-f	Director	Maryland Cecil		Port	Deposit					1 ☐ Yes 2 X No	
	with th	Dire	10e. Street and Number			10f. Zip Code			-	n of What Coun	•	
	death o	Funeral	1 Oak Court	2. Was Decedent Ev	er in U.S.	21904 13. Was Decedent of If Yes, specify Cub		ecify Yes or No		ited Sta	an Indian,	
177	of Z IZ 13-0030 filed within 72 hours after death with the Maryland Hygiene. Wher then 'natural', or itema 23s or 28s-f ehow ont, the Medical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	:	If Yes, specify Cub 1 ☐ Yes 2 🛣 No		Rican, etc.)		Black, White, pec <i>ify:</i> Whi		
	72 hours	Completed	15. Decedent's Educ (Specify only highest grade		16a. D	ecedent's Usual Occu Give kind of work done ife. DO NOT use retire	pation during most of work	ing	16b. Kind	of Business/Inc	dustry	
2 5	within then.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT use retire Homemaker	9 <i>d)</i>		Tn	Her Own	n Home	
7	be filed within that Hygiene. It other then event, the Mysele	e Co	17. Father's Name (First, Middle, Last)			Homemaker	18. Mother's Name	e (First, Middle			i Home	
5	uld be Mental rrked d	ToB	Frank Gerald Pow	e11			Emma S	Schlink:	man			
9	iore, interfigient ZIZ.	ľ	19a. Informant's Name/Relationship (Type			Mailing Address (Stree						
0	t, to		Frederick Dierke			Oak Court,		Date		nd 21904 Lition - City or To		
1/3	F Pa		1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Gilpin Memoria	Disposition (Name of commatory or other pla Manor 1 Park	Novem	nber 8, 06	E1ktc	on, Mary	land	
7	Dall permit. Departn Imports eny inju	١.,	21. Signal re of Funeral Service License	. L		Hicks Home	e for Fune	erals, F	A.	Manula	nd 21021	
1			21. Signal re of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Trecurror									
	Physician	-										
	/Medical Examiner		resulting in death)	Due to (or as a							- 1	
	Examine		Sequentially list conditions, if any, leading to immediate b. Severe Sapsic Cue to (or as a consequence of):									
√.	uted d ansit	Examiner	cause (Disease or injury									
<u> </u>	cate be executed physicien and the buriat-transit		that initiated events cresulting in death) Last	Due to (or as a	consequence of):						
	ate be e hysicier the buri	licai										
3	D = 01 #	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of			-		230	d. Date of delive	erv	
	deeth cert e attending d for use a	Iciar	in the past 12 months?	1 Live birth 2 4 Pregnant at tir		3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	су			Month	Day Year	
Ø Ø	S, F.C. es that the de igned by the be detached	Phys	9 🗆 Unknown	9□ Unknown								
ع ع	dS, F	ρ	Part II. Other significant conditions con	tributing to death but	not resulting in t	he underlying cause g	even in Part I.	23e. Did 1 □ 1			ne cause of death?	
	ecords, law requires t as been signe 2 should be	eted	Hamit Ciss	L'ESTONES.		M.C.LA	-great	24a. Was	-		,	
ء ر	VICAL REC sician: The law scertificate has b lirector, page 2 s	Completed	Liver Ci	- Cho-		, ~		auto	psy ormed?	prior to cor death?	psy findings available impletion of cause of	
\$ 3	Ital	0	25. Was case referred to medical	Calro	uto	450	26. Place of Deat	1 ☐ Yes		1 ☐ Yes	2□ No	
OT :	OT VICA Physician: this certific ral director,	To B	examiner? 1 Yes 2 No	lospital: 1 Dinpatient	2 ☐ ER/Outp	atient 3 DOA	ther: 4 Nursing Ho	ome 5□Resi	dence 6[Other (Specifi	y)	
_ ^	Jn OT ding Phys After this funeral di		27. Manner of Death 1 SNatural 5 □ Pending	28a. Date of Injury (Month, Day	(ear) 28b. Tir	me of 28c. Inju	ury at ork?	28d. Describe				
٢	JIVISION I or Attending after death. Director: After I in by the fune	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Injun	/ - At home fare	M 1 []Yes 2 □No	28f Location (Street and i	Number or Rura	i Route Number,	
iera	after after d in by	Certification:	4 Homicide determined	building, etc.	(Specify)	ii, siroot, lactory, cince		City or To				
Di	Division of Vital Re To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To th withir To th	M	29b. Signature and title of certifier			29c. Licer	nse number			signed (Month,		
			Ch?	= MD			53568			ber 4,	2006	
	2		30. Name and address of person who co	L-	ith (Item 23a) (T	ype, Print) 500 a	pro Chase	parke	R	ad		
		ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1201	Air Pleas	yana	2	1047		
	Regist		NOV 1 5 20		H	Road o						
	DHMH 17 Rev 1/2	2001	The Value of Land	- January Company		A MARIA						
					OF	IIGINAL						

State of Maryland / Department of Health and Mental Hygiene 1 1 5 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** 2006 1730 P ^M Helen Marie Dunlap November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner E1kton Ceci1 Union Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F Yrs. 65 June 8, Maryland 218-38-4131 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23s or 28s-1 show eny Injury or other treumatic event, it a Medical Evantical must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 TNo Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 United States 1153 Singerly Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker In Her Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Esther Kebler James Ellwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1153 Singerly Road, Elkton, Maryland 21921 Don F. Dunlap, Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 9, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkton Cemetery 2006 Elkton, Maryland Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signatule of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Troke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) physicien and the burial-transit The law requires that the death certificate be executed P.O. Box 68760. use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably icete hes been siç page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 Yes 2 No After this certificete 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification; Natural 2 Accident 5 Pending Injury after death, 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral D Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) e u 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier empleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 400 mr 31. Date filed (Month, Day, Year) gistrar's Signature State

Registrar

NOV 15

ORIGINAL

06-08060 Please Type or Print in Black Indelible Ink Paul Frederick Dabler State of Maryland / Department of Health and Mental Hygiene 2006 36287 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2 Date of Death Month Day October 26, 2006 1253 hrs **Medical Examiner** Pau1 <u>Frederick</u> <u>Dabler</u> 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of **Funeral** Foreign Country) Hours Min. Months Days Director 485-30-5019 1 X M 2 Yrs 74 March 21 193 Illinois Usual Residence of Decedent 10a State 10b. Count 10c. City. Town or Location 10d Inside City Limits 28a-f show d at once. Yes 2 X No MD St. Mary's Lexington Park Director 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 23a or 2 45730 Oregon Way 20653 U. S. A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U S 14 Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 2 1 X Yes 3 X Widowed Give Year 152 4 Divorced 154 1 Yes 2 X No specify Specify White à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) other than "the Medical E Baltimore, MD 21215-0036 and Mental Hygiene Manager Service Station 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) item 27 is marked traumatic event, t Be <u>(Unavailable)</u> Ruth Lamb 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health and: If item 27 Michael Dabler Son 3978 North Gate Place Waldorf, Maryland 20602 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: injury or oth MD Veterans Cemetery Nov.1,2006 Cheltenham, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Brinsfield-Echols Funl. Hme., P.A. 21 Signature of Funeral Service Licenses 30195 Three Notch Rd. Charlotte Hall, MD 20622 Physician Medical Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure List only one cause on each line Between Onset and Death Cardiac arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of Hypertensive atherosclerotic cardiovascular disease following assoult Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical X UNPENDED physician the burial -AMENDED #23a-b.27.28a-f. eprME. g862, 12/.27/06 TT Box 68760 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Fetal death Dav Year Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions Ö contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 3 Records, P. Yes 2 No 3 Probably 4 🗸 Uriknown Completed peen 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of certificate has performed' death? Yes 2 1 🗸 Yes 25. Was case referred to medica Division of Vital 26. Place of Death (Check only one) Be examiner? Other 4 2 CR/Outpatient 3 Inpatient DOA Nursing Home 5 Residence 6 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Natural 5 Pending 1 Yes 2 X No unknown 10/26/2006 subject assaulted 2 Accident Investigation

Hospital or Attending Physician: n 24 hours after death
re Funeral Director: A
letely filled in by the fu within 2 To the 1

28f. Location (Street and Number or Rural Route Number, City or Town, State) 45730 Oregon Way 28e Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined X Homicide (Specify) residence and street exington Park. MD 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

ne and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

and manner stated

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c License number

O.C.M.E

29d. Date signed (Month, Day, Year)

October 27, 2006

State Registrar

Medical

29b Signatu

31. Date filed (Month, Day, Year)

ORIGINAL

		For State Registrar	State o	f Maryla			of Health a	and Menta		ene 0 0	6 36288		
Physicia		Decedent's Name (First, Middle Linda	e, Last) Anne				1	2. Date Mon		Death Day Year 3. Time of Death A 2006 (1.57) M			
/Medic Examin		4a. Facility Name (If not institution Washington Coun				own, or Location o		4c.		c. County of Death			
Funeral Director		5. Social Security Number 219–44–4061	6. Sex 1 □ M 2 🕅 F		. last birthday) Yrs.	If Under 1			of Birth oth, Day, Y	(ear) 1945	Birthplace (State or Foreign Country) Georgia		
ith the Maryland or 28s-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Washington Hagerstown 1½ Yes 2 □ No											
with the	Director	10e. Street and Number 911 Marshall St.				10f. Zip C			U.S.A	•			
I by Middly (all of the first control of the Maryland of Health and Mental Hygiene. The thin and Mental Hygiene. The time Z? is marked other than "naturelt, or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marital 3 Widowed 4 Divorced	edent Ever in torces? 2 X Nove ve ates:						No- 14. Race - American Indian.				
within 72 ho iene. 'then "netur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teachers Assistant				16b. Kind of Business/Industry Special Education			
2 should be filed within and Mental Hygiene. Is marked other than raumalic event, the Mental Hygiene.	To Be C	17. Father's Name (First, Middle, Linwood Reedy	Last)				18. Mothe	er's Name <i>(First, I</i> ueline K	Middle, Ma	iden Sumame)			
and 2 sho ealth and m 27 is m		19a. Informant's Name/Relations L. Glenn Dunn/H			1	-		er or Rural Route Hagersto		-			
Pages 1 and of Height of H		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation		State	Place of Dispo	natory or oth	er place)	Date			ity or Town, State		
permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 is eny injury or other trea		4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 11/8/2006 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742											
Physician /Medical Examiner points from the pring-transit the pring-transit	ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one suse on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
The taw requires that the death certificate are hes been signed by the attending phys page 2 should be detached for use as the	hysiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic preg Other (spec				23d. Date of delivery Month Day Year					
w requires that been signed be should be deta	by P	Part II. Other significant condition	sulting in the u	ou (use given in Part I.	23e		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown					
n: The lawricate hes be	Completed	Acate renal facture. COPD							24a. Was an autopsy autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No				
ysiclar ysiclar iis certif director	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No 26. Place of Death Chec Cither: 4 Nursing Home 5							eck only one) 5 Pesidence 6 Other (Specify)				
United the Hospital or Attending Physician: The faviling a within 24 hours efter death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification:	1 √Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation								8d. Describe how injury occurred			
Ital or At irs efter d ral Direct lled in by													
he Hosp in 24 hou he Fune pletely fil	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the heat of my knowledge death occurred at the time date and place and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To t To t	W	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Nov 47h									Month, Day, Year) 47h 2006		
10		30. Name and address of person Dr. Mahmy.	A	se of death (Ite	orther	Print) A	ve 1.	troj. Ma	1 2	1742			
Sta Registr		31. Date filed (Month, Day, Year) NOV 1 5	En.	egistrar's Sign	nature A	ack! o		7					

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an Thomas El	lison	State of	f Maryland / Depa	rtment c	of Health ar	nd Mental	Hygiene	200	00000
		1- For State	Cer	tificate o	f Death		De.	eg. No. ZUU	6 3628!
Dl		Registrar 1. Decedent's Name (First, Middle,Last)					2. Date of Deat	.g. 110.	3 Time of Death
Physicia edical Exami		Alan	Thomas	Elli	son		Month November		0845 hrs
edicai Exaiiii	liei					1 (D -			
		4a Facility Name (if not institution, give s	treet and number)		4b. City, Town, o	r Location of De	atn	4c. County of Dear	ın
		Twilley Bridge Road			Salisbury			Wicomico	
Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Ye			th(MM/DD/YYYY) 9. B	
Director	- 1	218-06-5182 ₁ X _M	1 2 F 22	Υr	Months Day	ys Hours M	^{Min.} 08/21	./1984 Fore	ountry) Maryland
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1ary 28a-	Director	10e. Street and Number			10f. Zip Code	0.5	11	0g. Citizen of What Co	untry?
death with the Maryland or items 23a or 28a-f show must be notified at once.	ᡖ	117 Tall Timber L	ane		218	26		USA	
vith s 23,	펼	11. Marital Status	12. Was Decedent Ever in U.	S. 13. W	as Decedent of H	ispanic Origin? (Specify Yes or No-		rican Indian, Black,
ath v	Funeral	1 X Never Married 2 Married	Armed Forces?	lf '	Yes, specify Cuba	n, Mexican, Pue	erto Rican, etc.)	White, etc.	
er de		3 Widowed 4 Divorced If	1 Yes 2 X No Yes, Give Year	1	Yes 2 X N	n specify:		Specify:	white
s aft ral"	ğ	15. Decedent's Education (Specify only	or Dates:	16a Docodo	nt's Usual Occupa		of work done	16b Kind of Business	
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Thomas Edward Elli	son				l Emerson		
21 Duild Me man	ျ	19a. Informant's Name/Relationship (Typ						nber, City or Town, Stat	
MD 21215-0036 4 2 should be filed within 72 hours after death with the Maryland that and Monda I Fygien with 72 hours after death with the Maryland in 27 is marked other than "natural", or items 23a or 28a-f she unmatic event, the Medical Examiner must be notified at once	.	Thomas E. Ellison	/father	11	7 Tall T	imber L	ane, Frui	tland, MD	21826
- p = = = 1		20a Method of Disposition			osition (Name of co	emetery,	Date	20c. Location - City of	or Town, State
Ore ges 1 of H if i		1 X Burial 2 Cremation 3	Removal from State	chwood	other place) Memoria	al I.	1/10/06	D	MD
imore, MD 2121. Pages 1 and 2 should be finent of Health and Mental 1 iant: If item 27 is marked or other traumatic event,		4 Donation 5 Other Specify:	Ce	matari	7	-	1/10/06	•	s Anne, MD
Baltimore, permit Pages I an Department of Hea Important: If iter injury or other tra		21. Signature of Funeral Service License	e	2	Name and Addres	Funeral	Home Pro	fessional	Association
11. = . = .		Leit K Veriney	CESP))	OT DUOM	пттт ка	· / Salisc	oury, MD 21	804
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Box 68760, cath certificate be the attending physicile doruse as the buried for use as t	Je J	IF FEMALE	23c. If yes, outcome of preg		erne, goor	<u>• 11/30/(</u>	D.11	23d. Date of delive	ery
87 tiffica ng pl as th	2	23b. Was decedent pregnant in the	1 Live birth	-	etal death 3	Ectopic pre	gnancy	Month	Day Year
ox 687 eath certific	cia	past 12 months?	4 Pregnant at time of de	eath 5 (Other (Specify)			3	
30) death	ys	1 Yes 2 No 9 Unknown	9 Unknown						
O. F t the by th achee	Phy	Part II. Other significant conditions	ontributing to death but not r	esulting in the	underlying cause	given in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
ires that the signed by	<u>چ</u>						1 Yes	s 2 🗸 No 3 🗌 Pr	obably 4 Unknown
S, quire quire si an si ald b	Completed	-		-			24a Was	an 24b. Were a	autopsy findings available
orc w re us be shor	음						autop	osy prior to	completion of cause of
Reco The law icate has page 2 s	Ę						1 ✓ Yes	rmed? death?	
tal Recian: The certificate		25. Was case referred to medical			26.Pla	ce of Death (Che	eck only one)		
ita icia s cer recte	æ	examiner?	spital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	Other Nu	rsing Home 5	Residence 6 ✓ Oth	er: Scene
Division of Vital Records, tal or Attending Physician: The law requints at after death as after death led in by the funeral director, page 2 should be in by the funeral director, page 2 should be asset of the page 2 should be asset of the page 2 should be asset of the page 2 should be asset of the page 2 should be asset of the page 2 should be asset of the page 2 should be asset of the page 2 should be asset of the page 2 should be asset of the page 2 should be asset of the page 2 should be asset of the page 2 should be asset of the page 2 should be asset of the page 2 should be asset of the page 2 should be asset of the page 2 should be asset of the page 3	ြို	1 ✓ Yes 2 No	28a. Date of Injury	28b. Time o		jury at Work?		how injury occurred	
n of ding Pt After funeral	ë	1 Notural	(Month, Day, Year)		1	Yes 2 No		, ,	
ttem Heath tor:	∯	2 Accident Investigation	Fnd 11/6/2006	Fnd 8:	15 am _	X	unknown		
Vis or A fiter or A in by	≌	3 Suicide 6 X Could not be	28e. Place of Injury - At h	ome, farm, str	eet, factory, office	building, etc.	28f. Location (i or Town, S	Street and Number or F State) Turi 11ex	Rural Route Number, City 7 Bridge Road
Divising the price of the price	Certification:	4 Homicide determined	(Specify) Found in	n woods			Salisbur	v. MD	~LIUGO MOCH
Host 4 ho Fund ely f		29a. Certifier 1 Certifying Physician	n: To the best of my knowled	ge, death occ	surred at the time,	date and place,	and due to the caus	se(s) and manner as sta	arted
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	Medical	one) 2 Medical Examiner:	On the basis of examination a						
To To	ĕ	29b Signature and title of ceptifier	and manner stated		29c. Licer	nse number		29d Date signed (M	lonth, Day, Year)
	-				0.0	C.M.E.		November 7, 20	
		- //							
		30. Name and address of person who co					MD 0400:		
	1	Mary G. Ripple MD. Dept	uty Chief Medical Exa	miner 1	11 Penn Stree	et, Baltimore	, MD 21201		

9 2006

State of Maryland / Department of Health and Mental Hygiene 005 36290 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Jay Aldine Eby 0835AM November 01 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown 7. Age (In yrs. last birthday)
60 Yrs. Months Days Hours Min. (Month, Days August 8 5. Social Security Number 6. Sex **Funeral** Birthplace (State or Foreign
Country) 100 M 2□ F 1946 219-60-3987 Director Maryland Usual Residence of Decedent should be filed within 72 hours after deeth with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other then "natural", or items 23a or 28e-f show traumatic avent, the Medical Examinar must be notified at Penna. Franklin 1 ☐ Yes 2 No Director Greencastle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12270 Malissa Dr. 17225 U.S.A. Completed by Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental and Mental Isaac M. Eby Eva Lee Martin 2 ..OTE, M.
..ermit. Pages 1 and 2 sho.
Depertment of Health ~.
important: if Itar ~.
any injury ~.
once 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith L. Eby/Wife 12270 Malissa Dr. Greencastle, Pa. 17225 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Reiff Mennonite Church Cemetery 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/4/06 Cearfoss, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zimmerman And Son Funeral Home 45 S. Carlisle St. Greencastle, Pa. 17225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 monton NECLOSIZ **Physician** 10 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner riching HSPEXCILLOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physicien end for use as the burial-transit to to to by the sequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of deliven 2 Fetal death 3 Ectopic pregnancy Month , the e 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown be detact signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Vunknown peen s 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📈 Ño 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After or Attanding s effer de. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide To the Hospitat o within 24 hours eft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062607 30. Name and address of person who completed cases of death (23a) (Type, Print) 10 1130 Opal court Hoger stown MD 21746 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 1 5 2006 Registrar

The law requires that the death certificate be executed use as the burial-transit Box 68760 be detached for Records, P.O. Division of Vital

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 29,2006 Antonina Figurelli Oct. 4:00 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 9 Maplewood Park Court Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Director 578-60-4277 87 Yrs. Jan.31,1919 Italy Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits in then "neturel", or items 23s or 28s-f show the Medical Examiner must be notified at Bethesda ¥☐Yes 2☐No Directo Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 USA 9 Maplewood Park Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fur Finisher Garfinckel's 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental b is marked of Francesco Ulizio Anna Bruno 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 sh Depertment of Health and Important: if Item 27 is m eny injury or other treum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna F. Sachs/Daughter 9 Maplewood Park Ct., Bethesda, Md. 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 2 Burial 2 Cremation 3 Removal from State Nov.3,2006 Silver Spring, Md. Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Mineral Service Licer 22. Name and Address of Facility DeVol Funeral Home Kuzu A 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Years Profound Anemia /Medical Due to (or as a consequence of): Examiner Myelo dysplastic syndrome 8 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D23783 Oct. 30, 2006 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe Esposito, M.D., 5530 Wisconsin Ave. #1400, Chevy Chase, Md. 20815 Danies
31. Date filed (Month, Day, Year)
OCT 3 1 Daniel J. egistrar's Signature State

Registrar

				State of Mary				-	_	
			1 - For State Registrar	olato ol many		rtificate of			2006	36292
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death 6:45 P M
	/Media	cal	Thelma Elizab 4a. Facility Name (If not institution, give st		oaw	4h City Town	or Location of Death	October	Day Year 25 2060	2
	Examir	ier	Fathney Keedy M		tome	Boon			washir	1
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)		place (State or Foreign
	Director		216-28-2979 Usual Residence of Decedent	M 21X F	95 Yrs.			Aug 29		land
	/land		10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	B Mar	ctor	Maryland Washing	gton	Boons	boro				1 ☐ Yes 2 No
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Cou	ntry?
	eath v	eral	8507 Mapleville 11. Marital Status		in II S 13		21713	ocify Ves or No-	U.S.A.	can Indian
2 6	or Item	Fun	1 Never Married 2 Married	 Was Decedent Ever Amed Forces? 1 ☐ Yes 2 ☐ No 			lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
7	ours a	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛈 No	Specify:		Specify: Wh	ite
The min	within 72 hours after death with the Maryland ene. than "natural", or tems 23a or 28e-f ehow the Nedical Exama or must be trofilled at	Be Completed	15. Decedent's Educa (Specify only highest grade	ation com <i>pleted)</i>	16a. Dece	edent's Usual Occup e kind of work done	oation during most of worki d)	ng 16	6b. Kind of Business/Ir	dustry
45 5	within iene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)			∽ rative Ass		Hospita	1
P. Jand	be filed Ital Hygi od other	3e C	17. Father's Name (First, Middle, Last)			TIGHT TITE	18. Mother's Name			±
3 E	2 should be filed within and Mental Hygiene. Ie marked other than aumatic event, La Me	To	Charles Sapp				Viola	unknown		
h pawy	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artment of Health and Mental Hygiene. ordent: if item 27 is marked other than "natural", or Items 23a or 28e-f show injury or other traumatic event, the Macical Exama ar must be indified at 9.		19a. Informant's Name/Relationship (Typ						City or Town, State, Zij	
'e 2	os 1 and 2 of Health item 27 r other tra		Dale M. Phoebus (20a. Method of Disposition	daughter)	0b. Place of Disp	9 Lindsay	y Lane Hag	erstown Date 20	Maryland 2 Oc. Location - City or T	1742 own, State
元島	Pages nent of I int: If its		1 Surial 2 Cremation 3 Re 1 Donation 5 Other (Specify)			ematory or other pla l Cemeter	v Oct		Parkville	
FIS Baltimore	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License						Fiery Fune	ral Home
	20 = 29	/	Dunglo H.	liny	1	331 Easte	ern Blvd	N Hager	stown Mary	land 21742
			23a. Part1. Enter the disease, or complic shock, or bear failure. List only one	ations that caused the cause on each line.	death. Do not er	iter the mode of dyli	ng, such as cardiac c	r respiratory arres	it,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	whyse	ne				-
	Examiner		Sequentially list conditions b.	Due to (01 as a co	isoqualiza oi).					
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a co	nsequence of):					
_	be executed sician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a co	nsequence of):					
760,	ite be ex iysician ne burial	calE								
68	rtificate ng phy as the		u.							
Вох	ath cer Itendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pr 1 ☐ Live birth 2 ☐	Fetal death 3	□Ectopic pregnanc	у		23d. Date of deliv	ery Day Year
P.O. E	res that the death certifica igned by the attending ph be detached for use as th	by Physician/Med	1 Yes 2 No	4☐Pregnant at time 9☐Unknown	of death 5	Other (specify)			Monar	Day Toal
ر. ح.	s that the ned by a detain	y Ph	Part II. Other significant conditions cont	ributing to death but no	ot resulting in the	undertying cause giv	ven in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
rds	w requires been sig should be	ed b						1 🗆 Yes	2 □ No 3 □ Prol	pably 4 Denknown
ecc	law re las be	Completed						24a. Was an autopsy	prior to co	opsy lindings available impletion of cause of
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Zi.	sicien certifi irector	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	ospital:	2 ER/Outpatie	ent 3 DOA Ott	26. Place of Death		ce 6 □Other (Speci	, ,
Jou	ding Physicien: h. After this certific funeral director,	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Yes			y at	28d. Describe how		9)
sior	endin Bath. or: Aft he fur	atlo	1 Matural 5 Pending 2 Accident investigation	(Monar, Bay 70	ar) Irijary		Yes 2 □ No			
Division of Vital Records,	or Att	rtific	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, larm, si pecify)	treet, lactory, office		281. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
	To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edical Certification; To	29a. Certifier 1 Certifying Physi	cian: To the best of m	y knowledge, dea	th occurred at the tir	me, date and place,	and due to the cau	se(s) and manner as s	tated.
	n 24 h n 24 h he Fui pietely	edic	(Check only 2 Medical Examination one)	er: On the basis of exa and manner stated.						
	To the To the Complex complex	Σ	29b. Signature and title of certifier			29c. Licens	se number	290	d. Date signed (Month,	Day, Year)
			1 Klark	/	(h	Do	05036	2 (uctober	26,2006
1	H-2		30. Name and address of person who con	pieted cause of death	(Item 23a) (Type	erson R	Blvd. S	miths	Burg m	Day, Year) 26,2006 Day 21783
	Sta		31. Date filed (Month. Dav. Year)	32. Registrar's	Signature	P. A			J	
	Registi	rar	OCT 3 0 200	10 Been	13. D.	oured				

			1 = For State Registrar	State of	Maryland		artment of F rtificate of		ınd Men		ene () (36	36293
6.		ik;	1. Decedent's Name (First, Middle,	Last)						ate of Death	Day	Year	3. Time of Death
	Physici /Medic		Mary Louise	Fleming						tober		006	1:45 A M
À.	Examin	- 1	4a. Facility Name (If not institution,	give street and numb	per)		4b. City, Town, o	r Location of	f Death		4c. Count	y of Death	
			21060 Hermanvil	le Road			Lexingt	ton Pa	ırk		St.M	ary's	
	Funeral		5. Social Security Number 6	5. Sex 7. 1 ☐ M 2 🛣 F	. Age (In yrs. la		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. D Min. (/	ate of Birth Month, Day,	Year)	9. Birtho	place (State or Foreign
140	Director		579-36-9137	ILIM ZIAIF	76	Yrs.			Ma	y 18,1	1930		yland
	pur *		Usual Residence of Decedent 10a, State 10b, County		10c City	, Town or Lo	ncation						10d. Inside City Limits
	sho	2	,	•									1 ☐ Yes 2 X No
	289-f	Director	Maryland St.Mar	y's	Lex	ringto	n Park			10	- 0:::		
	with o	ē		1 5 1			10f. Zip Code			10	g. Citizen of	Wnat Coul	ntry?
	8 23	Funerai	21060 Hermanvil				206				USA		
	er de	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deced Armed Forc d 1 Yes 2	es?	3.	Was Decedent of H If Yes, specify Cuba	iispanic Orig an, Mexican,	, Puerto Ricar	n, etc.)		ce - Ameni ick, White,	can Indian, etc.
36	rs aft	by F	31√2 Widowed 4 □ Divorced	If Yes, Give Year or Dat			1 ☐ Yes 2 XX No	Specify:			Speci	y: B1	ack
옹	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23s or 28s-f show wit, It a Medical Examinational Secretified at		15. Decedent's			16a. Dece	dent's Usual Occup	ation		1	6b. Kind of E	lusiness/ir	duetor
5	in 72	Completed	(Specify only highest	grade completed)		(Give	kind of work done DO NOT use retired	during most	of working			301110004111	
12	than in	E O	Elementary/Secondary (0-12)	College (1-4	tor 5+)	Tea	cher's A	ide			Publi	c Sch	001
0	Hyg oths	Be C	17. Father's Name (First, Middle, La	ast)		-			r's Name (Firs	st, Middle, M.			
a	id be ental ked o	To B	Joseph S. Barne	· S				Mar	y R. E	doctor	,		
E Z	should ind Men ind marke umatic	-	19a. Informant's Name/Relationshi	· · · · · · · · · · · · · · · · · · ·		19b. Mailir	ng Address (Street					State, Zij	Code)
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, it a Medical Examination must be notified at ance.		Joyce Marie Barr	es/Daught	er	2106	0 Hermany	/ille	Road L	exingt	on Pa	rk, M	D 20653
Baltimore, Maryland 21215-0036	f Hei item othe		20a. Method of Disposition			ace of Dispo	osition (Name of matory or other place	1	Date		0c. Location		
Ë	Pages nent of I int: If its ury or o		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ale		Heart of Ma	1 1/	ovember 2006	,	ovinata	n Dami	Manaza am d
≣	permit. Page Department. Important: If any Injury o		21. Signature of Funeral Service L		Tallio	22	2. Name and Addre	ss of Facility	у				, Maryland
m	Depa Impo any Ir		Muchailta	Jad.	aux: >	N	Mattingley-0 1590 Fenwi	Gardine	r Funera	1 Home,	P.A.	50	
	\$		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that car	used the death							50	Approximate
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8760,	cate be executed physician and the burial-transit	cal		d									
9	iffica g ph as th	led											
Вох	death certific attending pl	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco									
m.	deat	icia	in the past 12 months?				Testa più aragna pa				23d. Da	ate of delive	эгу
<u>о</u> .	che the		1 ☐ Yes 2 ☐ No	4☐Pregnai	th 2 🗍 Fetal nt at time of de		Ectopic pregnancy Other (specify)	/				ate of delive	ery Day Year
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DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	aryland / [Departme <i>Certifica</i>			Mental Hyg R	iene (16	36294
	hysici /Medic		1. Decedent's Name (First, Middle, La Wilbert Do		eshman				2. Date of Dear Month Oct 26,	Dav	Year	3. Time of Death 1431 M
	xamin		4a. Facility Name (If not institution, given Calvert Memoria					Frederi		4c. County	of Death	ert
	ineral ector		212-38-3534	6ex 7. Ag 1⊈M 2☐ F	ge (In yrs. last bir 66	thday) If Und Months	er 1 Year Days	Hours Min.	8. Date of Birth (Month, Day, Sep 7,	1940	9. Birthp Coun Was	place (State or Foreign http) shington, DC
Maryland	f ehow	or	Usual Residence of Decedent 10a. State 10b. County MD Calve	ert	10c. City, Town	n or Location erland			-		1	0d. Inside City Limits
with the	d be noted	Funeral Director	10e. Street and Number 1231 Lake Ridge	Drive		10f. Z	ip Code	 689	1	0g. Citizen of W	/hat Coun	itry?
s after death	or Heme 2	by Funera	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 🛣 If Yes, Give	?	13. Was Dec	edent of His ecify Cuban		pecify Yes or No- Rican, etc.)		- Americ k, White,	ean Indian, etc.
U Z IZ I 3-0030 filed within 72 hours after death with the Maryland Hygiene.	item 27 ie marked other then "natural", or iteme 23e or 23e-f enow other traumatic event. It's Mudical Examiliar must be notified at	Completed b	15. Decedent's Elementary/Secondary (0-12)	Year or Dates: ducation ade completed) College (1-4or	5+)	Decedent's Us (Give kind of w life. DO NOT Self Em	rork done du use retired)	iring most of worl	king	16b. Kind of Bu		dustry eatment Sale
should be filed wi	arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last	eshman		peri m			ne (First, Middle, M	faiden Sumam		aument sare
and 2 sho	m 27 le mu her traume		19a Informant's Name/Relationship (Gloria Fleshman		12	31 Lake	Ridg	e Drive	Sunderl	and, M	20	689
permit. Pages 1 and 2 Depertment of Health a	Jury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	(y)	cemeter	Disposition (Name of the property of the prope	other place, 'Y	200	6	Clinton	, MD	
Dermii	eny in		21. Signature of Funeral Softice 1:00	Walee		8125 S	outhe.	rn Maryl	e Funera and Blvd	. Owin		E-(122) California 25 22 (127)
	dical		23a. Part1. Enter the disease, or an shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. META	d the death. Do rine.	ic L			or respiratory arre	est,		Approximate Interval Between Onset and Death
	pnysicien and street st	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence							
A GO/ GO,	ding physic se as the b	/Medical	IF FEMALE:	d	of prognancy							
the death of	by the attending prestached for use as ti	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐Ectopic p 5 ☐ Other (s				23d. Date Mon		ry Day Year
quires that	should be deta	by	Part II. Other significant conditions of	contributing to death b	out not resulting in	the underlying	cause giver	in Part I.	23e. Did tob 1 ☐ Ye	5.0		e cause of death? ably 4 DUnknown
The law re	page 2	Completed					-		24a. Was ar autops perform 1 Yes 2	/ pi led? di	ere autoprior to coneath?	osy findings available npletion of cause of 2 \(\text{No} \)
ng Phys	neral di	lon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatii 28a. Date of Inju	iry 28b. T	ime of	OA Other 28c. Injury a Work?	4 Nursing Ho	th Check only one one 5 Reside 28d. Describe ho	nce 6 Othe)
To the Hospitel or Attendi	ad in by the f	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of in	ury - At home, fai c. (Specify)	rm, street, facto		es 2 No	28f. Location (Str City or Town	eet and Numbe State)	r or Rural	Route Number,
the Hospit	completely filled in by	Medical	Check only 21 Medical Exal	nysician: To the best miner: On the basis o and manner st	t examination and	3/or investigatio	וומס עדת חג ח	non death occur	red at the time da	to and place as	of dup to	the cause/s)
¥ ¥	<u> </u>		29b. Signature and title of certifier	Vegel	m)	29	C. License i	16358	29	OCT.	(Month, C	200678
10			30. Name and address of person who JB H ~ 31. Date filed (Month, Day, Year)	completed cause of c	leath (Item 23a) (Type, Print)	PRIN	CF FI	REDER	ict.	M)	20678
a R	Sta legistr		OCT 2	7 2006 Negistr	LACIACI I	H April	west					

			A 170	epartment of Health and Mental Hy Certificate of Death	/gien 2006 36295 Reg. No.
	Physici		1. Decedent's Name (First, Middle, Last) Mary Angeline Fink	2. Date of Do Month	eath Day Year 3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and number) WMHS-Braddock Campus	4b. City, Town, or Location of Death Cumberland	4c. County of Death PREGUNY
	Funeral Director		5. Social Security Number 220-28-9328 G. Sex 1 M 2 M F 7. Age (In yrs. last birtho	Months Days Hours Min (Month D	9. Birthplace (State or Foreign ay, Year) Maryland
	e Maryland 3a-f show tiffed at	ctor	10a. State 10b. County 10c. City, Town of	or Location ernport	10d. Inside City Limits 1 Ğ Yes 2 ☐ No
	3a or 28	Il Director	10e. Street and Number 102 Cromer St.	10f. Zip Code 21562	10g. Citizen of What Country? United States
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "naturel" or Iteme 23a or 28a-f show any Injury or other traumatic event, the Modical Examinant has maified at ange.	by Funeral	11. Marital Status 11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2020No Specify:	o- 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	d within 72 ho piene. r then "natur the Madical I	Completed	(Specify only highest grade completed) ((Clementary/Secondary (0-12) College (1-4or 5+)	lecedent's Usual Occupation Give kind of work done during most of working ife. DO NOT use retired) ssistant Manager	16b. Kind of Business/Industry Department Store
yland ;	ould be fited Mental Hyg erked othe	To Be C	17. Father's Name (First, Middle, Last) Arnold W. Fink	18. Mother's Name (First, Middle Alice Duckwo	rth
, Mar	and 2 sh leith and 27 is rr er traum			Mailing Address (Street and Number or Rural Route Numb 9 Cromer St., Westernport,	
Baltimore,	Pages 1 ament of He ant: If Item ury or other		1 Translation 3 Removal from State cemetery,	Disposition (Name of crematory or other place) Cemetery 11/11/ 2006	20c. Location - City or Town, State Westernport, Maryland
Balt	permit. Departimport eny Inj		21. Signature of Funeral Service Licensee 7 Wank Sol	22. Name and Address of Facility Boal Fundamental Boal Fu	eral Home rt, Maryland 21562
8760,	Physician and physician and physician and physician and the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)	use athoroschutie Asi	Interval Between Onset and Death
O. Box 6	ath certifi ittending I or use es	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
rds, P.	w requires that the de been signed by the e should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
al Records,		Completed	is claric carling pithy	24a. Wa auto peri	
Division of Vital	I or Attending Physicien: The I after death. Director: After this certificate he I in by the funeral director, page	Certification; To Be	25. Was case referred to medical examiner? 1	ne of 28c. Injury at 28d. Describe	
DIV	or At aftar of Direction by		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	City or To	(Street and Number or Rural Route Number, wn, State)
	To the Hospital within 24 hours of To the Funeral completely filled	ledical	one) 2 Medical Examiner: On the basis of examination and/o	death occurred at the time, date and place, and due to the or investigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. , date and place, and due to the cause(s)
)	vit con	Σ	29b. Signature and title of certifier	29c. License number 290 18216	29d. Date signed (Month, Day, Year)
_			30. Name and address of person who completed cause of death (Item 23a) (Ty	900 sefon Dr (w	uberland MD
Ł	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Small	

06-08537

Please Type or Print in Black Indelible Ink

Judith Ann Fultz State of Maryland / Department of Health and Mental Hygiene 2006 36296 Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 9, 2006 Medical Examiner 0723 hrs Judith Ann Fultz 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 728 West Pulaski Highway Apt. 1 Elkton Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director Country) Indiana 219-42-1684 1 M 2 X F Yrs SEPT 1. 1943 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits any 1 Yes 2 X No 28a-f show Ceci1 E1kton Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 這 728 West Pulaski Highway, Apartment 1 21921 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces? White, etc. 1 Never Married 2 Married Yes 2 X No If Yes, Give Year 1 Yes 2 X No specify: 3 Y Widowed Divorced White Specify: Examiner ş 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Cabinet permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other tranmatic event, the Medical E Baltimore, MD 21215-0036 Machine Operator Manufacturing 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Clifford L. Benham Crystal J. Barker 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Mount Street, Christopher A. Fultz/Son Rising Sun, Maryland 21911 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State November West Chester, crematory or other place) Burial 2 X Cremation 3 Removal from State R.A. Ferris & Co., Inc. 10, 2006 Pennsylvania Donation 5 Other Specify Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licenses Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death Fluoxantine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospita or Attending Physician: The law requires that the death certificate be executed and sician/Medical X UNPENDED AMENDED #23a,27,28a-f, perME, g862, 12/16/06 TT Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was oecedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Ph Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ examiner? Inpatient 2 DOA ER/Outpatient 3 Nursing Home 5 Residence 6 🗸 Other. Scene After this 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year 28d Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 v No Fnd 11/9/2006 | Fnd 7:00 am unknown 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number of Rural Route Number, City or Town, State) /28 W. Pulaski Hwy. Apt1 6 X Could not be within 24 hours after To the Funeral Direct 3 Suicide determined (Specify) 4 Elkton, MD Homicide House 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Aignature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. November 10, 2006 Munite Mule 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 5 2006 32. Registrar's Signature State

Registra

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		- Hegistrar			timoate of L	Julii	Heg	J. No.				
Physic /Med		Decedent's Name (First, Middle, Las	Ruth	GRO	SS		2. Date of Death October 27, 2006 3. Time of Death 11:55 P					
Exam		4a. Facility Name (If not institution, give 8100 Connecticut		411	4b. City, Town, or Chevy C			4c. County of Death				
Funera Directo		5. Social Security Number 577 –03 –1 594	7. Age (li ☐ M 2 [X] F	n yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Y July 18,	9. Birth	place (State or Foreign intry) 1 Sylvania			
Maryland f show	tor	Usual Residence of Decedent		Oc. City, Town or Lo					10d. Inside City Limits 1 ♥Yes 2 No			
with the 3a or 28a	i Director	10e. Street and Number 8100 Connecticut			10f. Zip Code 2081	5	_	. Citizen of What Cor nited Stat	*			
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or terme 23e or 28e-f show eumatic event, the Madical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto i	ocify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: wh:	, etc.			
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. mportant: If Item 27 ie marked other then "naturel", or nny helury or other treumatic event, the Madical Exami	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, emaker	ition luring most of work!!)	ng 16	Own Home	ndustry			
/land uld be filed Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) Jacob Gro	ossman			18. Mother's Name Clara E		iden Sumame)				
'e, Mar'y 1 and 2 sho Health and 1 1 em 27 le ma		19a. Informant's Name/Relationship (7 Bonnie Park Brodsk		1.	ng Address (Street a			City or Town, State, Z	ip Code)			
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 is marked any Injury or other treumatic en		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify) I		osition (Name of matory or other place of Memoria	1	./06	c. Location - City or 1				
Depart Import		21. Signature of Funeral Service Lican		> T	2. Name and Address orchinsky 54. Cerrol	Hebrew F			20012			
/Medica Examined		23a. Part. Enter the disease, or companions, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Let	a. Liver Fail Due to (or as a co	Lure onsequence of): ilure onsequence of): iferative		, such as cardiac o	r Pespiratory arresi	500. , 20	20012 Approximate Interval Between Onset and Death			
15, F.O. BOX 68/60, res that the death certificate be executed signed by the ettending physicien and be detached for use as the burial-transit	lan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2Δ No 9 □ Unknown Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)										
HECOIDS, P.O. E The law requires that the dea te has been signed by the et oage 2 should be detached to	ed by Physic	Part II. Other significant conditions co	ontributing to death but n	ot resulting in the u	nderlying cause give	n in Part I.		cco use contribute to	the cause of death?			
	Completed						24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of 2 No			
ISION OF Itending Physicals. Geath. ctor: Atter this the funeral di	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Sp. 27. Manner of Death 1 North, Day Year) 27. Manner of Death 1 North, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No 28d. Describe how injury occurred Work?										
pltal or ours ette ours ette		4 Homicide determined 29a. Certifier 1 Cartifying Phy (Check only 2 Madical Exam	28e. Place of Injury building, etc. (5) vsician: To the best of minar: On the basis of ex	Specify)	h occurred at the tim	e, date and place, a	City or Town, S	se(s) and manner as	stated			
To the Hos within 24 h To the Fur completely	Medical	29b. Signature and title of certifier	and manner stated	. M	29c. License		29d	and place, and due Date signed (Month	. Day, Year)			
1		30 Name and address of person who s	completed serves of death	di	Daine)							

Registrar

State

31. Date filed (Month, Day, Year)

OCT 3 1 2006

Susan Stein, M.D., 2440 M Street, NW #804, Washington, DC

32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

3

2006

	1- State of Maryland / Dep Registrar	artment of Health and Mertificate of Death	fental Hygiene	36299
Physician	1. Decedent's Name (First, Middle, Last) Lowell C. Greene		Date of Death Month Day	3. Time of Death
/Medical Examiner	4a. Facility Name (II not institution, give street and number)	4b. City, Town, or Location of Death	October 25, 20	ol Death
Funeral	203 McKendree Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 461-46-2595 12 M 2□ F 74 Yrs.	Annapolis If Under 1 Year II Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Arundel 9. Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent		Sept. 10, 1932	Texas
Marylan Hed at	10a. State	ocation Annapol:	is	10d. Inside City Limits 1 XYes 2 No
3a or 28s	10e. Street and Number 203 McKendree Avenue	10f. Zip Code 21401	10g. Citizen of W	hat Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Department of Health and Mental Hygiane. In the cream of the standard of the control of	11. Marital Status 11. Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race Black Specify:	- American Indian, s, White, etc. White
Maryland 21215-0036 at 2 should be itled within 72 hours aft ith and Markal Hygiane. 27 is marked other than "natural", or rireumatic event, the Marical Example To Re Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+	dent's Usual Occupation a kind of work done during most of work DO NOT use retired) Management		siness/Industry sportation
aryland (should be filed not Mental Hygunarked othe umarked othe umartic event,	17. Father's Name (First, Middle, Last) Frank Greene		e (First, Middle, Maiden Sumame llian Leuter)
, Mary and 2 shot ealth and h n 27 is ma		ing Address (Street and Number or Rura Bold Venture Driv		
Baltimore, semil. Pages 1 ar beginnend of Hea mp. of Hea mp. of Hea mp. of Hea mp. of Hea mp. of Hea mp. of the sone.	I Dutial 2 K Cremation 3 Bernoval from State	osition (Name of matory or other place) re Crematory 10/29		city or Town, State
Balt permit. Dependimpedent		2. Name and Address of Facility Joh 17 Duke of Gloucest		
S8760, Medical Examiner at the burial transit and Examiner at the burial transit and Examiner at the burial transit and Examiner at the burial transit and Examiner at the burial transit and the burial trans	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Infartion ArTery Dis	ense	Approximate Interval Between Onset and Death Immediate
Box 6 death certification of for use as itclan/Me		□Ectopic pregnancy □ Other (specify)	23d. Date Mont	of delivery th Day Year
ecords, P.O law requires that the law requires that the las been signed by the 2 should be detache policited by Phys	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I. Alcoholic	23e. Did tobacco use contrit	bute to the cause of death? B Probably 4 Unknown
The ate has page			autopsy pr performed? de	ere autopsy findings available ior to completion of cause of satt? Yes 2 No
F Vital F vita	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 EP/Outpatier	26. Place of Death	(Check only one) me 5 P Residence 6 □Other	(04)
On of other th funeral funeral funeral	27. Manner Death 1 Protection 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 2 Accident investigation		28d. Describe how injury occurre	
Division of Division of State	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, lactory, office	281. Location (Street and Number City or Town, State)	r or Rural Route Number,
Hospi 4 hour Fune ely fill	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Madical Examinar: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurr	and due to the cause(s) and man ed at the time, date and place, ar	ner as stated. nd due to the cause(s)
To the within 2 To the complet	29b. Signature and title of certifier Frenh Frenh M.D	29c. License number	29d. Date signed	(Month, Day, Year)
1041	30. Name and address of person who completed cause of death (Item 23a) (Type, 116 Defense		MD 21401	
State Registrar	31. Date filed (North, Day, Year) OCT 3 0 2006 32 Registrar's Signature	roll j		

		Please	Chata of M					•		-egible.	
		1 State	State of M	aryland /		rtment of F tificate of I			2	006	36300
		Registrar 1. Decedent's Name (First, Middle, Las	st)		Cert	incate or i	Dealli	2. Date of Dea	Reg. Ne⊷ ith	000	3. Time of Death
Physici		Samuel Ra	•					October		2006 ar	11:48 A.M
/Medic Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or	Location of Deat		T	County of Dea	
		710 Charlotte Cour	rt			Prince	Frederic	k	Ca	lvert	
Funeral		5. Social Security Number 6. S		je (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h , Year)	9. Bir	thplace (State or Foreign ountry)
Director		212–88–9521 2 Usual Residence of Decedent		32	Yrs.			Sept. 7	, 19	74 Mar	yland
rland OW		10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside City Limits
Man a-f ah	ţo	Maryland Calvert		Princ	e Fr	ederick					1 ☐ Yes 2X No
iled within 72 hours after death with the Maryland Hygiene. Hygiene they in the maryland sther than the maryland in the them industries and the market to inclined at any in the market in the inclined at	Director	10e. Street and Number		·		10f. Zip Code			10g. Citiz	en of What C	ountry?
23a	rai	710 Charlotte Cour	:t			20678				ed Sta	tes
er deg	une	11. Marital Status	12. Was Decedent Armed Forces?	,	13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	. 1	 Race - Am- Black, Whi 	
rs afte	by Funeral	1 ☐ Never Married X☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 I If Yes, Give Year or Dates:	№ 1992-	- 1	□Yes 2XNo	Specify:			Specify:	hi to
2 hou		15. Decedent's Ed	lucation	1995	a. Decede	ent's Usual Occup	ation		16b. Kin	d of Business	hite Andustry
Pin 7:	ple	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or	5+)	(Give k life. D	rind of work done of O NOT use retired	during most of wor d)	rking			ŕ
er tha	Completed		4		ctor	/ Model			Ente	rtainm	ent
d all H	Be	17. Father's Name (First, Middle, Last)						ne (First, Middle,		Sumame)	
should be nd Mental marked o	2	Kenneth Robert Gr						noir Gre			
		19a. Informant's Name/Relationship (and Number or Ru				
thealth		Carla Jean Gross 20a. Method of Disposition	(wire)				Court,	Prince F		TICK,	
partimore, we permit. Pages 1 and 2 Department of Health a important: If Item 27 is any Injury or other training.		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		1		ition (Name of atory or other place	l l				
artme artme ortan injur		21. Signature of Funeral Service Lie n		Mecro			ss of Facility R				, Virginia
permit. Departrimportri		1466	**								land 20676
O PORT		23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that cause	d the death. Do	- '						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Car		1						Onset and Death
/Medical		resulting in death)	Due to (or as	a consequence	e of):						years
Examiner	L	Sequentially list conditions.	b								
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	e of):						
be executed ician and burial-transit	xan	that initiated events resulting in death) Last	cDue to (or as	a consequence	e of):						
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w requires that the death certificate been signed by the attending phys should be detached for use as the	ledi		0.								
th cer lendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		th 3∏F	Ectopic pregnancy			2	3d. Date of de	•
e dea the at	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a: 9 ☐ Unknown			Other (specify)				Month	Day Year
hat th bet by detacl		Part II. Other significant conditions o	ontohuting to death h	out not resulting	in the un	derhina cause and	an in Part I	23e Did to	hacco us	e contribute to	the cause of death?
signe d be d	d by	at me and engineers contained o	orking to dod!!!	at not rosalling	, ar the dia	Jony ing Cause give	on in raici.		es 2		robably 4 DUnknown
shoul	ete							24a. Was		24h Wore a	utopsy findings available
he la e has	Completed							autop	sy med?	prior to death?	completion of cause of
en: T	a	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes	2 X No	1 🗆 Yes	2 No
nysici	To B	examiner? 1 Tes 2 XNo	Hospital: 1 Inpate	ent 2 ER/C	Dutpatient	3 DOA Oth	er: 4 🗆 Nursing H			Other (Spe	ecify)
ng Ph fter th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju	y Year) 28b	. Time of Injury	28c. Injun Worl	/ at k?	28d. Describe h			
tendii leath. lor: A	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □No				
or At or At office of the by	Certification:	4 Homicide determined	286. Place of in	ury - At home, c. <i>(Specify)</i>	farm, stre	et, factory, office		28f. Location (S City or Tow		Number or R	ural Route Number,
spital		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowled	ge death	occurred at the tim	ne date and place	and due to the	aneo(e)	and manner a	c stated
To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the House Director add and the Funerel Director. The this security of the Punerel Director. The this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medical Examone)	niner: On the basis o and manner st	f examination a ated.	and/or inve	estigation, in my o	pinion, death occu	rred at the time, o	late and	place, and due	o to the cause(s)
To th Withir To th comp	M	29b. Signature and title of certifier				29c. License	e number	-	9d. Date	signed (Mont	h. Day, Year)
		sabel	flet	MI		Doc	5906	1	Oct	ober	30,2006
10+1		30. Name and address of person who ARATI PATEL	completed cause of c	leath (Item 23a	O Type, P	Print)	uite a	12 Pr	MI	Free	tenck
Sta Registr		31. Date filed (Month, Day, Year) OCT 3	32. Registr	s Signature	H.	Sparke					30; 2006 80; 2006 80; 2006

State Registrar DHMH 17 Rev 1/2001

-08009		Please Type or Print in Black Indelible In	k		
omas Henry (Gray	y, Jr. State of Maryland / Department of Health and Menta	al Hygiene		
		1- For State Certificate of Death		200	6 36301
Dhusisi	/	Registrar	2. Date of Dear		3 Time of Death
Physici		mi v	Month	Day Year	
edical Exami	mer		October 2		0730 hrs
		4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of I	Death	4c. County of Dea	th
		21687 Saratoga DRive Lexington		St. Mary's	
Funeral		5. Social Security Number 6 Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 2	24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9 B	rthplace (State or
Director		Months Dave Houre	Min	Fore	ign
Director		213-56-3071 1XM 2 F 57 Yrs World S Days 10015	07/23	/1949 c	ountry) Maryland
		Usual Residence of Decedent			
any		10a State 10b. County 10c. City, Town or Location			10d Inside City Limits
- × ×	4	MD St. Mary's Lexington Park			1 Yes 2 XNo
ith the Maryland 23a or 28a-f show any <u>notified at once,</u>	Director				
Mar 28a dat	2		1	0g. Citizen of What Co	untry?
a or tiffe	۵	21687 Saratoga Drive 20653	1	USA	
s 23	ᅙ	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	? (Specify Yes or No	- 14 Race - Ame	rican Indian, Black,
ath rem	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, P		White, etc	
a de	교	1 Y Yes 2 No		7.4	
afte	þ			Specify: B1	ack
atu sam	9	15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kir during most of working life DO NOT us		16b. Kind of Business	/Industry
72 h	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	se retired)		
bin hin edic	ᅙ	12 Bus Driver		Transpo	rtation
With Mark	Completed	17. Father's Name (First, Middle, Last) 18.Mother's	Name (First, Middle, N		
G H g		Thomas Henry Gray, Sr. Glad		Blake	
21215-0036 und be filed within 7 Mental Hygiene marked other thau c event, the Medica	Be		•		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Importment: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	입	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 19b. Mailing Address)			
Baltimore, MD bernit. Pages I and 2 sho Department of Health and Important: If item 27 is nigury or other traumati		Delores M. Gray/wife 21687 Saratoga	Dr. Lexi	ngton Par	k, MD20653
anc anc Heal		20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City of	r Town, State
Or ges l of l		1 XBurial 2 Cremation 3 Removal from State crematory or other place)	0/01/06		
Pag ment or o		4 Donation 5 Other Specify Evergreen Mem.Gar.1	0/31/06	Great M	Hills, MD
alt part por ury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Sewell	Funeral H	lome
™ 50 € 50		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1451 Dares Be	ach Road	Prince F	red.,MD
Physician		23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care			Approximate Interval
/Medical		failure. List only one cause on each line.			Between Onset and
Examiner		Immediate Cause (Final disease a Intraoral gunshot wound			Death
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	ner	if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause			
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A	dical	UNPENDED AMENDED			
	<u>ĕ</u>	IF FEMALE: 23c If yes, outcome of pregnancy	-	23d Date of delive	8/
Box 68760, c death certificate bethe attending physic of for use as the but	1	23b Was decedent pregnant in the 1 Live birth	regnancy	Month 23d Date of deliver	Day Year
cert mdir	<u>.e</u>	past 12 months?	regrianty	Month	Day
eath for t	Si.	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown			
the d	Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	1 230 Did to	bacco use contribute to	a the enuse of death?
P.O s that t	À	Contributing to death but not resulting in the underlying cause given in Part			
res 1			1 Yes	S 2 No 3 Pro	bably 4 V Unknown
ds deen deen deen	ompleted		24a. Was	an 24b Were a	utopsy findings available
aw las t	<u>ĕ</u>		autop	rmed? prior to death?	completion of cause of
Rec	5		1 V Yes		es 2 No
	Ü	25. Was case referred to medical 26 Place of Death (C	heck only one)		
ita sicia s ce irect	0	examiner? Hospital: 4 Inneticet 3 FD/Outreticet 3 004 Other		Residence 6 V Other	ne Canaa
Physical distribution	2	Tes 2 No			si. Scene
n O ing Afte	<u> </u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? FOUND: 28c. Injury at Work? FOUND: 1 Ves 2 N	Subject sho	now injury occurred	
or:	∺	1 Natural 5 Pending FOUND: 1 Yes 2 ✓ N	lo Gabjest sile		
'iSi'	👸	2 Accident Investigation OCt 25, 2006 0,730 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc	28f Location (S	Street and Number or R	tural Route Number, City
Division of Vital Records, piral nation of Vital Records, ours after death recentificate has been sittled in by the funeral director, page 2 should the director, page 2 should the control of the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	₹	Suicide 6 Could not be determined (Specify) Single Family	or Town, S	itate)	
프로등	Certification:			toga Drive, Lexing	
24 I 24 I E Fu etely	ल्ल	29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place			
Division To the Hospital or Attend within 24 hours after death To the Funeral Directors completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occu	rred at the time, date	and place, and due to t	he cause(s)
To To Con	Me	29b. Signature and title of certifier 29c. License number		29d Date signed (M	onth, Day, Year)
		5/ ///// O.C.M.E.			
		J. J. J. Recent.		October 26, 200	,0
		30. Name and address of person who completed cause of death (Item 23a)		•	
5		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Balti	more, MD 21201	1	
	tate	31 Date filed (Month, Day, Year) 32. Registrar's Signature			
Regis		and a a coord life of the state of			
					1

DHMH 17 Rev 1/2001 OCME 2006

			1- For State of Mary	land / Depa	artment of H	ealth and M	lental Hyg	iene 006	36302
	Phy	ysician	Decedent's Name (First, Middle, Last) POROUTING BARRY TO DECEMBER TO DESCRIPTION TO D	OIZ CROSS	T CVT D		2. Date of Deat Month	th Day Year	3. Time of Death
	//	ledical aminer	DOROTHY BARRI (4a. Facility Name (If not institution, give street and number)	CK GROSSI		Location of Death	Octobe	4c. County of Deat	
		annner	Fahrney-Keedy Nyrsin	a Home	0	sboro		Washir	
	Fun Dire		5. Social Security Number 6. Sex 7. Age (In 219-05-2734 1 \square M 2 \square 7. Age (In	yrs. last birthday). 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 10	9. Birti O, 1918 Mar	pplace (State or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Lo	cation				10d. Inside City Limits
0	a-f sho	ctor	Maryland Washington	Boonsbord)				1 Yes 2 No
I	with the	Dire	10e. Street and Number 8507 Mapleville Road		10f. Zip Code	713	10	0g. Citizen of What Co	untry?
٦,	death	nera	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13. V	J	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-	U.S.A.	
rossnic	d 21215-0036 filed within 72 hours after death with the Maryland Hyglene. wher than "natural", or Items 23a or 28a-f show	t, the Medical Examiner must be notified Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 XWidowed 4 Divorced Year or Dates:		Yes 2 No	Specify:	rican, etc.)	Specify:	n, etc. Thite
5	21215-0036 and within 72 hours aft giene.	olcal E	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ition uning most of worki	ng	16b. Kind of Business/l	
C	vithin liene.	ompl	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	NOT use retired, Secreta:			Bank	
3	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show	event, Be C	17. Father's Name (First, Middle, Last) Grover E. Barrick			18. Mother's Name			
12	Maryland of 2 should be file th and Mental Hy T Is marked othe	To	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	Emma Lat		City or Town, State, Z	ip Code)
2	and 2 and 2 m 27 ls	her tra	James W. Barrick / Nephew	2506	Coach Hou	ise Way U	nit 3D,	Frederick,	MD 21702
7	nore	y or of			sition (Name of natory or other place Cemetery			20c. Location - City <i>o</i> r 1 Rocky Ridge	
Soroth	Baltimore, permit. Pages 1 ac Department of Hear mportant: If item:	ny Injur	21. Signature of Funeral/Service Licensee			F		ERAL HOMES,	
	W 805	ă	23a. Parl 1. Enter the disease, or complications that caused the	61	5 EAST MA	AIN STREE	T, THURM	MD 21 (10)	788 Approximate
	Physic	ian	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	1/500	/ 0	07		,	Interval Between Onset and Death
	/Med Exami		resulting in death) a. Due to (or as a cor	nsequence of):	or or	y V			
	P	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	вачиние л).					
	8760, ate be executed hysician and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a cor	nsequence of):					
	68760 tificate be e	he bu	d			<u> </u>			
	Box 68 eath certific attending p	изе as п	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pri			11.1.2.2		23d. Date of deliv	(env
	. 0 0	letached for use as the second	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
	b P.O.	be detact	Part II. Dther significant conditions contributing to death but not	t resulting in the un	derlying cause give	n in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
	cords w requires been sig	ted b	Sentitud				1 ☐ Ye	s 2 No 3 Pro	bably 4 Obnknown
	Recombe law	page 2 should					24a. Was an autopsy perform	y prior to co	opsy findings available ompletion of cause of
	- 10	Be Co	25. Was case referred to medical examiner?			26. Place of Death	1 ☐ Yes 2 Check on one	-	2 □ No
	of Vita Physician: rthis certific	ral dire	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 DOA Othe	r: 4 Aursing Hon		nce 6 Other (Speci	ify)
	sion anding sath. or: Afte	he fune atlon	1 ĜNatural 5 ☐ Pending (Month, Day Yea 2 ☐ Accident investigation	nr) Injury	28c. Injury Work M 1 🗀 Y	? 'es 2 □ No	.50. 2030/100 /101	winding occurred	
	Division of Vital Records, to Attending Physician: The law requires the death. Director: After this certificate has been signe	ed in by the funera Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (Sp.	At home, farm, stre	et, factory, office	2	8f. Location (Str. City or Town,	reet and Number or Rui , State)	al Route Number,
	Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	pletely filled edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my one) 1 Medical Exeminer: On the basis of examiner stated.	knowledge, death mination and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the ca ed at the time, da	use(s) and manner as a ite and place, and due t	stated. to the cause(s)
	To th within To th	compl	29b. Signature and title of certifier		29c. License			d. Date signed (Month,	
	10		30. Name and address of person who completed cause of death	(Itam 22a) (Time 1		0360	3	10/31/20	006
	0				•	d, Smiths	burg, M	D 21783	
	Re	State gistrar	Vincent Cantone, MD 22911 J 31. Date filed (Month Pay Year) 1 2006 32. Figure 1 2006	ignature	souli				

	1 - For Amend Item 2. 1. Decedent's Name (First, Middle, Last)					· · ·		2. Date of Dea Month		Year	3. Time of Death
ian ical	Inomas Atten Gent							Oct.	29,2	006	04:03A N
ner						Location of				ounty of Dea	
	Harford Memorial 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Und	er 1 Year	e Gra	4 Hrs.	8. Date of Birth	1	arford 9. Bir	thplace (State or Foreig ountry)
	220-52-6013	M 2□F	57 Yrs.	Months	Days	Hours	Min.	Nov.7,1	948	Nora	th Carolina
	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation							10d. Inside City Limits
tor	MD Cecil		Rising S	Sun							1 □Yes 2 XN
Director	10e. Street and Number			10f. Z	ip Code			1	0g. Citize	on of What C	ountry?
		12. Was Decedent Eve	ar in 11 S 42 1		1911		-0 (0		USA		-it-di
Funeral	1 Never Married 2 Married	Armed Forces?	er in U.S. 13.	If Yes, sp	ecify Cubar	spanic Ungi n, Mexican,	n? (Spec Puerto F	ofy Yes or No- lican, etc.)	14	Black, Whi	erican Indian, ite, etc.
2	3 ☐ Widowed 4 Civorced	1 Y Yes 2 No If Yes, Give Year or Dates: 19	69-71	1 🗌 Yes	2)() No	Specify:			5	pecify: WV	rite
Ptor	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Dece	dent's Us kind of w	ual Occupa vork done d	tion uring most o	of workin	g	16b. Kind	d of Business	/Industry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Assemb						Au t	omotiv	10
Re C.			, vo och o	reg L			s Name	(First, Middle,			, e
70						Pau	line	Eller			
	19a. Informant's Name/Relationship (Ty			-				Route Number	-		Zip Code)
	Thomas A. Gentry 20a. Method of Disposition		20b. Place of Disponentery, crei	C TOLANDO	- N			lkton,		1921 ation - City or	r Town. State
	1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Hellioval Holli State	cemetery, crei Rosebank				1_1_				ı, Maryland
	21. Signature of Funeral Service License					s of Facility				77	i, margiana Iome, P.A.
	Wichard L	6000	le	111	S. Qu	een S	t.,	Rising	Sun,	MD 2	1911
	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused th ne cause un each line.	e death. Do not ent	ter the mo	ode of dying	, such as ca	ardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	Sept	ic SV	100	K						Onset and Death
		Due to (d as a d	consequence of):	SOP	Ilm	oni	0				24 hoc
של	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of):	-110	OVV	OFT	1/4	. 1			21,113
FYAMINA	Cause (Disease or injury that initiated events resulting in death) Last	Hypoi	natre	mi	9			111			24 hrs
Cal Ex		Due to (or as a c	consequence of):				Λ.	EDICAL EXAMINA	EK		
		I			-6	Vi	WED BY	EDIC			
M/U	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of 1 ☐ Live birth 2 (pregnancy	Testania		ATION ADDE			23	d. Date of de	livery
- 00	in the past 12 months?	4 Pregnant at tim	ne of death 5	Other (s	specify)					Month	Day Year
C			not reculting in the u	ndarkina	cauco ama	o in Part I				contribute t	o the cause of death?
Physician/Med	(0000	middling to dod in but i	tot tooditing in the d	noonying	cause give	ii iii i catti.		1 🗆 Ye	_	,	robably 4 Unknow
2								24a. Was a		24b. Were a	utopsy findings availabl
2								autops	med?	prior to death? 1 ☐ Yes	completion of cause of
2											20110
e Completed by	25. Was case referred to medical						f Death	1 □ Yes : Check only on	-01		
To Be Completed by	25. Was case referred to medical examiner?	Hospital: 1 X Inpatient	2 ER/Outpatier			r. 4 □ Nurs	ing Hom	Check only on e 5 ☐ Reside	ence 6		ecify)
To Be Completed by	25. Was case referred to medical examiner?	Hospital: 1 X Inpatient 28a. Date of Injury (Month, Day Y		f	28c. Injury Work	r: 4 □ Nurs at ?	ing Hom	Check only on	ence 6		ecify)
To Be Completed by	25. Was case referred to medical examiner?	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	f M	28c. Injury Work 1 □ Y	r. 4 □ Nurs	sing Hom	Check only on e 5 Reside 3d. Describe ho	ence 6	occurred	ocify) ural Route Number.
To Be Completed by	25. Was case referred to medical examiner?	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	f M	28c. Injury Work 1 □ Y	r: 4 □ Nurs at ?	sing Hom	Check only on e 5 Reside	ence 6	occurred	
Certification: To Be Completed by	25. Was case referred to medical examiner? 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Y 28e. Place of Injury building, etc. (- At home, farm, str Specify)	f M reet, facto	28c. Injury Work 1 TY	r. 4 □ Nurs at ? 'es 2 □ No	o 2i	Check only one 5 Reside 8d. Describe ho City or Town	ence 6 ow injury	Number or R	ural Route Number.
To Be Completed by	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Y 28e. Place of Injury building, etc. (28b. Time of Injury - At home, farm, str. Specify) my knowledge death camination and/or in	f M reet, facto	28c. Injury Work 1 Ty ry, office	at ? es 2 No a dalle and inion, death	o 2i	Check only on e 5 Reside d. Describe ho if Location (St City or Town d. at the time, d.	pence 6 ow injury treet and n, State)	Number or R	ural Route Number,
edical Certification: To Be Completed by	25. Was case referred to medical examiner? 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a Cerifier (Check only one) 25. Was case referred to medical examiner.	28a. Date of Injury (Month, Day Y 28e. Place of Injury building, etc. (28b. Time of Injury - At home, farm, str. Specify) my knowledge death camination and/or in	f M reet, factor vestigatio	28c. Injury Work 1 Y Try, office	4 Nurs at ? /es 2 No a date and inion, death	21 21 21 21 21 21 21 21 21 21 21 21 21 2	Check only on e 5 Reside d. Describe ho f. Location (Si City or Town d at the time, d	pence 6 ow injury treet and n, State) atte and p	Number or R	ural Route Number. t talod. e to the cause(s) th, Day, Year)
edical Certification: To Be Completed by	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Y 28e. Place of Injury building, etc. (sician: To the bed of ner: On the basis of ey and manner stated	28b. Time of Injury - At home, farm, str Specify) my knowledge death camination and/or indicates	f M reet, factor vestigatio	28c. Injury Work 1 Y Try, office	4 Nurs at ? /es 2 No a date and inion, death	21 21 21 21 21 21 21 21 21 21 21 21 21 2	Check only on e 5 Reside d. Describe ho f. Location (Si City or Town d at the time, d	pence 6 ow injury treet and n, State) atte and p	Number or R	ural Route Number,

				1 - State Amend Item	29dper D								_	36304
				1. Decedent's Name (First, Middle, La	ist)						2. Date of D	eath Da	y Year	3. Time of Death
	Ŧ	Physici /Medi Examir	cal	Lyttleton Lee Gra 4a. Facility Name (If not institution, gir		er)		4b. City	, Town, or	Location of Death	Niver	nber	County of Death	
		Exami		Harford Memorial				Hav	re de	Grace		H	larford	
		Funeral Director			Sex 7. 1 X 0 M 2 □ F	Age (In yrs.	last birthday) Yrs.	If Unde Months		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 04/14/			place (State or Foreign intry) LULand
		pr 😹		Usual Residence of Decedent 10a, State 10b, County		10c C	ty, Town or Lo	cation						10d. Inside City Limits
0150		the Marylar 28s-f show	tor	MD Harford	ł		vre de		e					1 X Yes 2 □ No
0		or 28	Dire	10e. Street and Number				ļ	ip Code				izen of What Cou	intry?
		eath v	erai	968 Chesapeake Di	ÚVE 12. Was Decede	nt Ever in I	18 12		21078		neofu Voe or N	USA	14. Race - Amer	ican Indian
11/4/06	36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 ts marked other than "naturel", or Iteme 23s or 28s-1 ehow other treumatic event, the Medical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4	Armed Force 1 [7] Yes 2 If Yes, Give Year or Date	os? □ No				ispanic Origin? (S) n, Mexican, Puent Specify:	Rican, etc.)	0-	Black, White	, etc.
11/6	Maryland 21215-0036	"nature	Completed	15. Decedent's E (Specify only highest gr	ducation	-wwz	16a. Dece	kind of w	ual Occupa ork done o use retired	during most of wor	king	16b. K	ind of Business/Ir	ndustry
	12	withir iene. then	ошо	Elementary/Secondary (0-12)	College (1-4	or 5+)	Inve)		Sol	K-Emploi	uod
	פַ	be filed tal Hygi d other event, I	BeC	17. Father's Name (First, Middle, Las	1)		2700	3 -20-2		18. Mother's Nam	ne (First, Middle			, cu
2	ylar	should be and Mental marked o	To	Lyttleton Sadler	Green					Nellie	Jane Pr	esto	n	
5889	Mar	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than other treumatic event, the M		19a. Informant's Name/Relationship						and Number or Ru				
	a)	Health tem 27 other tr		Polores Schultz- 20a. Method of Disposition	Companio	20b.	Place of Dispo	sition (Na	ame of	Dr., Ha	Date de		.e. MV 21 ocation - City or T	
200-	Ë	Pages nent of ant: If I		1 Donation 5 Other (Special Control of Cont		ite	cemetery, crer ael Hil	,	•	ru 11/1	0/06	Havr	ie de Gr	ace_MD
3/6-	Baltimore,	permit. Pages Department of timportent: If Ite eny injury or of once.		21. Signature of Funeral Service Lice	nsee	12 0				ith Fune ington,				
ie		42204	4	23d. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caus	sed the dea	th. Do not ent	er the mo	_Wash	<u>ungton,</u> g. such as cardiac	or respiratory	<u>le Gr</u> arrest,	ace, MD	Approximate
		Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	A								1	Interval Between Onset and Death
De		/Medical Examiner	ner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Rupt Due to (or b. Arte, Due to (or	as a consec 105 as a consec	quence of):	otio	()	ardiou	ascul	err	Discase	
18 # 3°	,092	ate be executed hysicien and he burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or	as a consec	quence of):							
haal	P.O. Box 68	ne death certific: the ettending pl hed for use as t	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	2 ☐ Feta tat time of c	al death 3	Ectopic	pregnancy specify)	•	t		23d. Date of,deliv	ery Day Year
	S, P.	signed by	by Ph	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the u	nderlying	cause give	en in Part 1.				the cause of death?
0	ord	v requires been sign should be	eted										□No 3□Pro	
7	Division of Vital Records,	iclan: The law certificete hes t rector, page 2 s	Compi							•	24a. Was auto perf 1 Yes	psy ormed?	prior to co death?	opsy findings available empletion of cause of
retal	Zį.	siclan certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				Othe	26. Place of Dea		-		
1	ō	Phys or this oral di	. To	1 Yes 2 No 27. Manner of Death	28a. Date of I (Month,		28b. Time of		28c. Injury Work	4 Nursing n	ome 5 Res 28d. Describe		6 □Other (Speci y occurred	fy)
丰	ion	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	on	Day Year)	Injury	м		(? Yes 2 ☐No				
11	Divis	is girth	Certification:	3 Suicide 6 Could not to determined	289. Place of	Injury - At h etc. (Speci	ome, farm, str	eet, facto	ry, office		28f. Location (City or To	Street an wn, State	d Number or Rur)	al Route Number,
		Hospital 24 hours e Funerel i letely filled	Medical	29a. Certifier to entity in P (Check only one) 2 Medical Exa	hysician: To the he miner: On the basi and manner	s of examina	owledge dealt ation and/or in	t oncurro vestigatio	d at the tim n, in my op	ie date and plana pinion, death occur	and dua to the red at the time	date and	and wanner as to place, and due to	umad o the cause(s)
		To the within 2 To the comple	Me	29b. Signature and title of certifier				29	c. License	number			te signed (Month,	
				faul for	Do				MS	5272		Nov	ember 6,	2006
	,	25		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type,	Print)	Do	brace	NI		Pool	1: Ht a Da
		Str	ate	31. Date filed (Menth, Day, Year)		strar's Sign	ature for	EL S		J. Mel	11 6		1 aux 1	1110 00
		Regist		MOA T 0 500	430319	cost of g	and the same of th	Phys. Sep.						

State Registrar 31. Date filed (Month, Day, Year)

3 1 2006

32. Registrar's Signature

			1 - For State Registrar	State of M	Maryland / Dep <i>Ce</i>	artment of Fertificate of		·		06	363	06
	Physici	an	1 Decedent's Name (First, Middle, Helen B. Hui					2. Date of De Month	Day 26, 2	Yeer	3. Time of E	Death PM
	/Medic Examin		4a. Facility Name (If not institution,		or)	4b. City, Town, o	r Location o		4c. County		8:00	1-
	Examin	e	Prince George'			Cheverl			Prin	ce G	eorge's	5
	Funeral		5. Social Security Number		Age (In yrs. last birthday		-	Min. (Month, Da	h y, Year)	9. Birthp	place (State or	Foreign
	Director		578-03-6962 Usual Residence of Decedent		91 '''s.			Oct. 2,	1915	Peni	nsylvan	ila
	yland 10W		10a. State 10b. County		10c. City, Town or L	ocation.				1	0d. Inside City	/ Limits
	Man	ţ	Marylan d Pri	nce George	's Ade	lphi					1 Tes	2X No
	3e or 28	Dire	10e. Street and Number 1820 Metzerot	t Road, #3	5	10f. Zip Code	0783		10g. Citizen of	What Cour USA	ntry?	
036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural," or items 23s or 28e-f show other traumatic event, the Medical Exaction must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 X Widowed 4 Divorced	12. Was Deceder Armed Force ad 1 Yes 24 If Yes, Give Year or Dates	§/ No	Was Decedent of H If Yes, specify Cub	dispanic Ori an, Mexican Specify:	gin? (Specify Yes or No n, Puerto Rican, etc.)	Bla	e - Americ ck, White, White	etc.	
21215-0036	in 72 ho "natur	Completed	15. Decedent's (Specify only highest	grade completed)	(Giv.	edent's Usual Occup e kind of work done DO NOT use retire	nation during most d)	t of working	16b. Kind of B	usiness/In	dustry	
212	d within giene. ir than "	mo:	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Accountar			Federal	Gove	ernment	:
Maryland	ould be filed Mental Hygii larkad other latic event, II	To Be C	17. Father's Name (First, Middle, L Albert Brezon	ast)			1	or's Name <i>(First, Middle,</i> Slanche Bend		ne)		
ary	2 should be and Mental is marked is umatic sv	۲	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mai	ling Address (Street	and Numbe	er or Rural Route Numbe	er, City or Town,	State, Zip	Code)	-
	and 2 saith a n 27 is		James R. Kleile	r/ Nephew	9721	Culver St	reet,	Kensington	, Maryl	and 2	20895	
Baltimore,	Pages 1 ar ent of Hea nt: if itsm ry or oths	1	20a. Method of Disposition 1			osition (Name of ematory or other pla eaven Cemete		November 2 2006	20c. Location			wlan
Balti	permit. Pages in Department of Figure in Important: If its any injury or ot once.		21. Signatur o Funeral Service L		É 5	22. Name and Addre rancis J.	ss of Facilit Coll sity	ins Funeral Blvd, W, Si	. Home I	nc.		
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	emplications that caus	ed the death. Do not en	nter the mode of dyi	ng, such as	cardiac or respiratory a	rrest,		Approximate Interval Betw	een
	Physician		Immediate Cause (Final disease or condition		Cerebral In	farction					Onset and De B Days	eath
4	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):							
н	LXdiffile	ų.	Sequentially list conditions,	b	Fibrillati	on			-	10) Years	<u>,</u>
	ted	n lu	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequence of.							
8760,	cate be executed physicien and the burial-transit	al Examiner	that initiated events ' resulting in death) Last	C. Due to (or a	as a consequence of):							
687	ficate physics the	edic		d								
P.O. Box	The law requires that the death certificate be executed ate has been signed by the ettending physicien and begge 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 GtNo 9 ☐ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnanc □ Other (specify) _	y			te of delive	,	ear
	ires that signed b d be deta	þ	Part II. Other significant condition Hypertension	15 contributing to death	but not resulting in the	underlying cause giv	ren in Part I.		obacco use cont res 212 No			
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Vital	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Check only o	ne)			
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on	After	盲	1 SNatural 5 Pending 2 Accident investiga		Day Year) Injury	Wo	rk? ∣Yes 2∐l		ion anjuly coour	.00		
Division	or Attendi	Certification:	3 Suicide 6 Could not determine	ot be 28e. Place of	Injury - At home, larm, s etc. (Specify)	treet, lactory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rura	I Route Numb	Θ <i>r</i> ,
_	To the Hospital or Attent within 24 hours effer deatl To the Funerel Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the basis and manner	st of my knowledge, dea of examination and/or i	ith occurred at the transvestigation, in my converted at the transverse at the trans	me, date an opinion, dea	d place, and due to the th occurred at the time,	cause(s) and ma	anner as si and due to	tated. the cause(s)	
	To the within To the comple	Me	29b. Signature and title ol certifier	(N)-	4	29c. Licens			29d. Date signe		-	
	12		30. Name and address of person w	to completed	July		21428 		Octobe	1 40,	, 2006	
			Linda Green, M.	D. 3001	Hospital Dr		erly,	MD 20785				
	Sta Registi		31. Date filed (Month, Day, Year) OCT 3 1	2006 32 egi	strar's Signature	carle						

P.O. Box 68760. Division or Vital Records,

To the Hospital o within 24 hours aft To the Funeral DI completely filled in

State Registrar

Sarah Bromeland, M.D.; 1500 Forest Glen Road; Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) OCT 3 1 2006

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

D62571

29d. Date signed (Month, Day, Year)

October 26, 2006

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Catherine Anne Hier-Majumder

		I- For State Registrar	,	Certifica	ate of De	eath			Re	g. No.	200	16 3630
Physicia		Decedent's Name (First, Midd	ile,Last)					l N	ate of Death	Day	Year	3 Time of Death
ledical Examir			NE HIER-MAJUM	DER				0	ctober 27	7, 2006		0938 hrs
- ad		4a. Facility Name (if not institution 7400 Wisconsin Aver				city, Town, or ethesda	Location of	Death			ounty of Dear ounty of Dear	th
Funeral		5. Social Security Number	6 Sex 7. Age	(In yrs. last birt		Under 1 Yea			Date of Birt	h(MM/DD/	YYYY) 9. B	irthplace (State or Foreign
Director		328-60-4458	1 M 2 X F	31	Yrs.	lonths Day	rs Hours	Mın.	11-10	-1974	·	ountry) Illinois
<u> </u>	F	Usual Residence of Decedent 10a. State 10b. County		I0c. City. Town	or Location							10d Inside City Limits
ow any												1 X Yes 2 No
faryland 28a-f show	핡	Maryland Princ	e George's	Colleg		f. Zip Code			110	a Citizen	of What Co	untry?
e Mar or 28a	Director		ster Park Drive	. Δnt		20740				U.S.		
ith the M		11. Marital Status	12. Was Decedent E			cedent of Hi	spanic Origin	n? (Specify	Yes or No-			rican Indian, Black,
ath w	Funeral	1 Never Married 2 X M	Married Armed Forces?	X No		specify Cuba					White, etc.	
iter de		3 Widowed 4 Div	1 Yes 2 vorced If Yes, Give Year	INO	1 Yes	2 X No	specify:			Spe	ecify Wh	nite
hours afte	d by	15 Decedent's Education (Spe	ecify only highest grade comp		Decedent's U				done	16b Kind	of Business	s/Industry
n 72 hc	ompleted	Elementary/Secondary (0-12)		+)			5. DO 1101 U	3c rolliou)			_	Institute
5-0036 led within 7 Hygiene lother than the Medica	Ĕ		5	S	cienti	.st	40 14-41	Maria (Fin	st, Middle, M			gton, DC
15-(filled v I Hygi of oth	O	17. Father's Name (First, Middle	, Last)						erbran		name)	
2121 ould be fil Mental I marked	o Be	Stephen Hier 19a. Informant's Name/Relation	ship (Type, Print)	19	b. Mailing Ad	dress (Stre					or Town, Stat	te, Zip Code) 20740
MD 21215-0036 of 2 should be filed within 72 hours after death with the Maryland tith and Mental Hygiene m 27 is marked other than "natural", or items 23a or 28a-f she anumatic event, the Medical Examiner must be notified at once	-	Saswata Hier		119								llege Park, MD
		20a. Method of Disposition		20b. Place	of Disposition	(Name of ce		Da				or Town, State
Baltimore, permit Pages lar Department of Hee Importaut: If iter			n 3 Removal from Stat	.6			atory	10/3	0/2006	A1e	xandr	ia, Virginia
Baltimo permit Pages Department o Important:	Ť	4 Donation 5 Other S 21. Signature of Funeral Service		TICCIO								, P.A.
in in Per B		Can detta	March &	annum	3.4				_			D 20781
Physician	\Box	23a Part I. Enter the disease, of failure. List only one cause	r complications that caused to	he death. Do ໂຈ	ot enter the m	ode of dying	, such as car	rdiac or res	piratory arre	est, shock,	or heart	Approximate Interval Between Onset and
/Medical Examiner	- 14	Immediate Cause (Final disease	Marking Lairedge									Death
_Adminion		or condition resulting in death)	Due to (or as a consec	quence of):								
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an a	/Medical	UNPENDED	AMENDED									
1760, ficate be exe g physician a	ě	IF FEMALE:	23c. If yes, outcom								ate of delive	
687 certification of the seast	ian/	23b. Was decedent pregnant in past 12 months?	Live Ditti				Ectopic	pregnancy		Mo	onth	Day Year
Box 68 • death certif the attending ed for use as	Physician	1 Yes 2 No 9 🗸 U			5 Other	(Specify)						
ords, P.O. Box 68 w requires that the death certif s been signed by the attending should be detached for use as		Part II. Other significant cond	itions contributing to death	but not resulting	g in the unde	rlying cause	given in Par	t I.				o the cause of death?
, P.O.	d by								1 Yes	2 N	o 3 Pr	obably 4 🗸 Unknown
rds requi	ete	1.1							24a. Was a		24b. Were a	autopsy findings available completion of cause of
e law te has	Completed								perfor	med?	death?	
tal Re- tian: The certificate		25. Was case referred to medic	al		·	26.Plac	e of Death (Check only				
Vita ysicia his cel direct	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/C	outpatient 3	DOA	Other ₄	Nursing H	ome 5	Residence	e 6 🗸 Oth	er: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death all Director: After this certificate has been siled in by the funeral director, page 2 should be		27. Manner of Death	28a. Date of Injur FOUND:	ry 28b.	Time of Injur	y 28c. Inj	ury at Work?		Describe			front of train
Sion of Actending Photograph Ctor: After 18 y the funeral	atio		nding FOUND: Destigation Oct 27, 2006		UND: 0 hrs	1	Yes 2	No Ou	ojeot rept	ortoury j	umpea m	mone or train
ViSI or At of At Orect in by	iţi	3 ✓ Suicide 6 Co	uld not be 28e. Place of Inju	ury - At home, f	arm, street, fa	actory, office	building, etc	1	or Town, S	tate)		Rural Route Number, City
Di spital of cours a filled	Certification:	4 Homicide	termined (Specify) Oth						00 Wisco	nsin Av		thesda, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit.	Medical		Physician: To the best of my caminer:On the basis of exam									
To To	Med	29b. Signature and title of certif	and manner stated fier			29c. Licen	se number			29d Dat	e signed (M	fonth, Day, Year)
		1/1	11 11.01.	T-0	A	0.0	.M.E.			Octob	er 28, 20	06
2(10)		3 Name and address of person	on who completed company	eath (tem 23a)	13,							
1413/)	Theodore M. King, J	r., MD. Assistant M			1 Penn S	treet, Ball	timore, N	/ID 21201	<u> </u>		
S Regis	tate frar		32. Registrar	's Signature	ell							
Negis	1121	0010240	pureus.									

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fb 8862 12-1-06 by State of Maryland Poepartment of Health and Mental Hygien 0 0 6

For State Amend Item #2
Registrar WCHD/SH 11/1/06 per Dr. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29,2006 Cart Physician JOHN FRANCIS HENRY, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Keedy - Nussing Home 6. Sex 7. Age (lasts. last birthday) Boonsboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. MARCH 17, 9. Birthplace (State or Foreign **Funeral** , Year) 1921 Months 1 X M 2 ☐ F PENNSYLVANIA 85 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director WASHINGTON BOONSBORO MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21713 8507 MAPLEVILLE ROAD U.S.A. Items 23e Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2XNo WWII 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 XWidowed 4 □ Divorced Year or Dates WHITE "naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Flementary/Secondary (0-12) College (1-4or 5+) 5+ VETERINARIAN ANIMAL CLINC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is 1 and 2 should ba fi of Health and Mental H item 27 Is markad ot CLARA ANNA KERN JOHN FRANCIS HENRY, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HEATHER MADDEX, DAUGHTER P.O. Box 1415, Shepherdstown Pike, Shepherdstown, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h permit. Pages Department of I Important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SMITHSBURG CREMATORY 11/02/2006 SMITHSBURG, MARYLAND 4 Donation 5 Other (Specify) 7606 OLD NATIONAL PIKE 22. Name and Address of Facility 21. Signature of Fineral Servee Licensee BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 Approximate Interval Between Onset and Death 23a. Part1 Enter the disease shock of heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final **Physician** Congective disease or condition resulting in death) /Medical Due to (dr as a consequence of): Examiner Sequentially list conditions, if any, backing to limit ediate cause. Enter Underlying Cause (Disease or injury burial-transit The law requires that the death certificate be axecuted Due to (or as a consequence of) that initiated events and resulting in death) Last attending physician for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Munknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 202 No 1 Yes Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4154 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After To the Hospital or Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide in by 4 Homicide within 24 hours a

To the Funerel C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/30/8 05 2323 30. Name and address of person who completed cause in ath (Item 23a) (Type, Print) Dr. Khalid Waseem, 1126 Opal Court, Hagerstown, MD 21740 31. Date filed (Month Day, Year) 32. Registrar's Signature State 2006

DHMH 17 Rev 1/2001

Registrar

Baltimore,

Box 68760.

	1 - For State Registrar	State of Marylar		tificate of			Reg. No. U	06	36310
Physician /Medical	Decedent's Name (First, Middle, L Charles Edwin Ha	arris, Sr.				2. Date of De Month Novemb	er 2, 2		3. Time of Death 3:45 A
Examiner	4a. Facility Name (If not institution, gastern St. Mary's Hos	,			or Location of Deat	h	4c. County		
Funeral		Sex 7. Age (In yrs.	last birthday)	If Under 1 Year			th	Mary 9. Birth	Y 'S nplace (State or Foreign untry)
Director	215-38-6834 Usual Residence of Decedent	XXM 2□F 64	Yrs.	Months Days	Hours Min.	(Month, Da April 1		Wasi	hington, D.C.
death with the Maryland ms 23e or 28s-1 show frivat be notified at reverse land of the result of the	Maryland St. Man		ty, Town or Loc chanics						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with the a or 28s	10e. Street and Number 26331 Abigial La			10f. Zip Code	559		10g. Citizen of		untry?
has 23	11. Marital Status	12. Was Decedent Ever in U	.S. 13. V			pecify Yes or No	- 14. Rac	USA e - Amer	ican Indian,
urs after		Armed Forces? 1 ☐ Yes 2 Who If Yes, Give Year or Dates:		Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Bla Specif	ck, White	e, etc.
Depertment of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural; any injury or other traumatic event, the Mudical Exa once. To Be Completed by	15. Decedent's I (Specify only highest g	rade completed)	16a. Deced (Give)	ent's Usual Occup kind of work done OO NOT use retire	pation during most of wor d)	king	16b. Kind of B		
r than	Elementary/Secondary (0-12)	College (1-4or 5+)		niture Re			Upho1s	stery	7
d other event,	17. Father's Name (First, Middle, Las	t)			18. Mother's Nan	ne (First, Middle,	Maiden Surnar	ne)	
Ment arkac atic	Willard Allen H					e Newton			
raum	19a. Informant's Name/Relationship				and Number or Ru				ip Code)
thar 1	Martha Christine Har			1 Abigia1 sition (Name of	Lane, Mecha	nicsville Date	MD 2065 20c. Location		Town State
0 T T	1 ⊠ Burial 2 ☐ Cremation 3	☐Removal from State	semetery, crem	atory or other pla	Nove	ember 8,			TOWIT, State
injury	4 Donation 5 Other (Spec			pel Cemete . Name and Addre		006	Vienna,	VA	
any tra	Thinhart Heur	29-1	/ Ma	ttingley-G	ardiner Fur k Street, 1	eral Home	, P.A.	50	
ysician	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the deat	h. Do not ente	er the mode of dyi	ng, such as cardiad	or respiratory ar			Approximate Interval Between Onset and Death
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ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events	b. Due to (or as a conseq	uence of): すること	ets,	arces f	_			minutes
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d by the ettending physicien end letached for use as the burial-transit Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3	Ectopic pregnanc Other (specify)	/			te of deliv	very Day Year
		contributing to death but not res	ulting in the un	derlying cause giv	en in Part I.				the cause of death?
% ∽ Cr	hypertians hypertians hypothymi makete	111 m				24a. Was		Were auto	opsy findings available
Page	- nabete	1 mellins				perfo	rmed?	death?	2 □ No
s certificate hes birector, page 2 s	25. Was case referred to medical examiner?	Hospital:		! O#		th (Check only o			
After this funeral of	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigative	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injui Wor	er: 4 \(\text{ Nursing H}\) y at k? Yes 2 \(\text{ No}\)	ome 5 Resid			rfy)
within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not determined	be Ose Steep of Leiter At he	ome, farm, stre y)			28f. Location (S City or Ton	Street and Numb m, State)	er or Rur	al Route Number,
thin 24 hours at the Funeral I mpletely filled	29a. Certifier 18 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, death tion and/or invi	occurred at the tire estigation, in my o	ne, date and place pinion, death occu	, and due to the or rred at the time, o	cause(s) and madate and place,	anner as s and due t	stated. to the cause(s)
within to the comple	29b. Signature and title of certifier	~		29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
	> 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			$\mathcal{D} \propto$	06171	9	11-6	1-0	6
	/	completed cause of death (Item	n 23a) (Type, F	Print)					
	Dr. Dilananjay Bhar 31. Deteriled (Month, Day, Year) 0 6 2006		hree Not	ch Road H	ollywood, M	laryland 2	0636		
State		32. Registrar's Signa							

			For State	State of Maryland					2000	26211
			Registrar		Cei	rtificate of I	Death	Reg.	NOZ U U D	3. Time of Death
	Physici	an	Decedent's Name (First, Middle, Last		_				Day Year	м
	/Medic	al		ert Hayes	, Jr		r Location of Death	NOVEMBER	4 2006 4c. County of Death	11:33 P "
	Examin	er	4a. Facility Name (If not institution, give							lary's
			St. Mary's Hospi 5. Social Security Number 6. Se		ast birthday)	If Under 1 Year	onardtown If Under 24 Hrs.	8 Date of Birth	9 Birth	place (State or Foreign
	Funeral Director			XM 2□F 76	Yrs.	Months Days	Hours Min.	(Month, Day, Ye	ar) Coi	uington, D.C
			Usual Residence of Decedent							
	how		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-f-	cto	Maryland St. Ma	ry's		Mechanic	sville			1 ☐ Yes 2 ☐ X No
	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow the Madical Exemitian mast be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			Citizen of What Co	
	23a	la l	26864 Oak Ridge				659		nited Sta	
	ement of the second	Tue	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	ori	by F	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:		Specify: W	hite
8	hour	pe pe	15. Decedent's Ed		16a Dece	dent's Usual Occup	ation	161	b. Kind of Business/	Industry
5	n 72	Completed	(Specify only highest gra	ide completed)	(Give	kind of work done	during most of world)	king		
12	withi Bne. than	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Diesel M			Automoti	.ve
9	filed Hygi Sther	BeC	17. Father's Name (First, Middle, Last)					e (First, Middle, Mai		
an	d be ental ked c	To B	Richard Albert H	Haves, Sr.			Della	Biggs		
2	shou nd M mar	-	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street		ral Route Number, C	ity or Town, State, Z	ip Code)
S	and 2 lith a 27 is r trau		Marian Hayes / W	Vife	26864	4 Oak Rid	ge Drive	Mechanic	sville, M	D 20659
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed withir Deportment of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other fraumatic event, Intel Monce.		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of matory or other place	ca)	Date 200	. Location - City or	Town, State
ê.	Page ent o nt: If ry or		1 Burial 2 Cremation 3 4 Donation 5 Other (Specification 5 Other (Specification)	memoval from State			1	9-2006 Le	onardtown	, Maryland
=	mit. I		21. Signature of Funeral Service Licer	X/				insfield F		
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Box	death certifica e attending ph od for use as ti	Jan A	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		⊒Ectopic pregnancy	v		23d. Date of del Month	ivery Day Year
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用う	Physicie this cert al direct	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Thpatient 2	ER/Outpatie	nt 3L DUA		ome 5 Residenc		cify)
HARD ALBERT HAYES JR. Division of Vital Records,	ding Ph h. After th funeral	ü.	27. Manner of Death 1 ☑ Platural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wo		28d. Describe how	injury occurred	
Sio A	endi eath. or: A	cati	2 ☐ Accident investigatio				Yes 2 □No		_	
ARI X	or Attendi efter death Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st y)	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
RICHARD Divis	itel c									
RI	To the Hospitel or Attending Physicien: within 24 hours efter death. To the Funaral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Example 1	hysiclan: To the best of my kno minet: On the basis of examina	wledge, dea ition and/or in	th occurred at the till ovestigation, in my o	me, date and place opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	within 24 To the F complete	Med	one)	and manner stated.		29c. Licens			Date signed (Mont	
	Viii To	-	29b. Signature and title of certifier	1/1		250. Licens	ao mumbol			
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	07"		30. Name and address of person who) AD 110777	IIOOD MADE	AND DOCC	
			21 Date filed (Month Day Year)	BHAVSAR 24035		NOTCH RO	DAD HOLLY	WOOD MARYI	LAND 2063	0
	St	ate	31. Date filed (Month, Pay, Year) 8	2006 32. Pegistrar's Signa	# 4	Seculi 1				

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	Physici		Decedent's Name (First, Middle, I Sugan Mary Sr		ın.				2. Date of De Month	Day		3. Time of Death
	/Medio Examir	_	Susan Mary St 4a. Facility Name (If not institution, 9 Casey House 60	001 Muncaste	er Mill		4b. City, Town, or Rock v	ille		4c.	County of Death	11:50 ÅM ry County
	Funeral Director		5. Social Security Number 6. 218–80–4492 Usual Residence of Decedent	. Sex 7. Age	47	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	th ay, Yea <i>r)</i> 31 19		hplace (State or Foreign untry) yland
	a-f ehow	ctor	10a. State 10b. County Maryland Mont	gomery	10c. City, To		hersburg					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	ath with the 23s or 28	ral Director	10e. Street and Number 49 Brassie Co				10f. Zip Code	0886		10g. Citiz	U.S.A	,
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow important: If Item 27 is marked other than "natural perceitled at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 M N If Yes, Give Year or Dates:		1	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No		Specify Yes or No to Rican, etc.)		14. Race - Amer Black, White Specify: Wh	e, etc.
D-0171	within 72 ho ane. than "natur 's Medical I	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	completed) College (1-4or 5-		(Give i	ent's Usual Occupa kind of work done of OO NOT use retired	ation during most of wo	rking		nd of Business/	Residence
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, Mary	and 2 shouselth and N n 27 is mar		19a. Informant's Name/Relationship	(Type, Print)			g Address (Street a	and Number or R	ural Route Numb	er, City or		
baltimore	Pages 1 tment of He tant: if iten		Robert Vernen 20a. Method of Disposition 11 Burial 2 Cremation 3 4 Donation 5 Other (Spec	cify)		Hav	en Cemete	ery 10	/31/06			n Maryland
Ö	Departiment Departiment Important Im		21. Signature of Funeral Service Lic	A Frin		13	Name and Addres 31 Easter	n Blvd.	N. Hage	rsto	ery Fund wn Mary	eral Home land 21742
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or hear failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line	_{e.} eatic	Canc		g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
,00,00	To the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours alter death. The farm thin 24 hours alter death this certificate has been signed by the attending physicien end for the Funeral Director. After this certificate has been signed by the attending physicien end completely tilled in by the funeral director, page 2 should be detached tor use as the burial-transit.	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or as a d.								
O. BOX 0	w requires that the death certific been signed by the attending p should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 🗆 Fetal dea		Ectopic pregnancy Other (specify)			2	3d. Date of deliving Month	very Day Year
cords, r.	equires that an signed by outd be deta		Part II. Other significant conditions	contributing to death bu	t not resulting	in the un	derlying cause give	en in Part I.		obacco us Yes 2 🎗	_	the cause of death?
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DIVISION	ial or Attend s atter death at Director: , ad in by the t	Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be Goo Blace of light	ry · At home, (Specify)	farm, stre		∕es 2 □ No	28f. Location (City or To	Street and wn, State)	Number or Rur	ral Route Number,
	the Hospit nin 24 hour the Funera npletely tills	edical	one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner stat	examination a	ga dealt and/or inv	estigation, in my op	oinion, death occu	and due to the irred at the time,	date and	place, and due t	to the cause(s)
	with To	Σ	29b. Signature and title of certifier Rynthia M					758032	2		ber 28	
H	-12 Sta		30. Name and address of person wh Cynthia M. Will: 31. Date filed (Month, Day, Year)	iams D.O. Mo		ery E	lospice 60	001 Munc	asker Mi	.11 R	oad Rocl	kville MD
	Registr	ar	NOV 0 1	2006	A.	1	arks)					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 26 2006 **Physician** 1415 George Hicks Sr. October /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner **Annapolis** Anne Arundel Anne Arundel Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Apr | 12 Year | 1945 5. Social Security Number 7. Age (In vrs. last birthdav 9. Birthplace (State or Foreign **Funeral X** M 2 □ F 61 Yrs. 214-44-9164 Virginia Director Maryland Anne Arundel 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 28a-f show la or 28a-f sho t be notified a Annapolis 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 21401 ns 23a must b 95 Clay St. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Saltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: **Black** þ 3 Widowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Ō Maintenance \$t. John's College 7 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Solo Owens Erma Lee Hicks ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health ? Helen L. Hicks(Wife) 618 Cyril Ave Pasadena, Md. 21122 Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any injury or o once. 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Metro Crematory 10-30-06 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. Lavy B, Leose MOS 483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) troke Physician 2da /Medical Due to (or as a consequence of) **Examiner** perteusius Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to () as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the as nse IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed' 1∐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XÎnpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident (Month, Day Year) 5 Pending ours after death. neral Director; A filled in by the for investigation 1 Yes 2 No Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29c. License number 29b. Signature and title of cortifler 29d. Date signed (Month, Day, Year) 2 MD

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registra

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31. Date filed (Month, Day,

State of Maryland / Department of Health and Mental Hygien 2006 36314 1 - For State Registres Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Clarence William Hellerich October 29, 2006 6:15 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Hermitage at St. John Creek Calvert Solomons If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, April 11, 9. Birthplace (State or Foreign **Funeral** Year) 1**X** M 2 □ F 1919 Pennsylvania 187-07-5871 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits rel', or items 23a or 28e-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13325 Dowell Road 20688 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: δ 3

Widowed 4 □ Divorced White "naturel" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry completed) Naval OATI Station Elementary/Secondary (0-12) College (1-4or 5+) 12 Grounds Foreman Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental Hillant: If item 27 is marked other. Eva Sipe Maurice Hellerich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Fratantuono (Personal Rep) 13525 Olivet Road, Lusby, Maryland 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriat 2 remation 3 Removal from State = 5 permit. Page Department Important: if eny injury or once. Metropolitan Crematory 10/30/06 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Road, Port Republic, Maryland 20676 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. tmmediate Cause (Finat LONGESTIVE FAILURE HEART **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DISEASE CORONARY ARTERY Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. ician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed be should be detail 23e. Did tobacco use contribute to the cause of death? ģ 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s certificate 1 Yes 2 No Attending Physician: 25. Was case reterred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) A SSIS Cold Certification: To 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9427 10 - 30 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) HOSPITAL R.D. Prince Frederick MD 20678 MUNSHI. MD . 110 ANWAR 32. Registres Signature 31. Date filed (Month, Day, Year) State 0 2006

DHMH 17 Rev 1/2001

Registrar

06-08378 Young Pyo Hong

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Physician/ dical Examiner 1. Decedent's Name (First, Middle, Last) YOUNG PYO HONG 2. Date of Death Month Day November 5, 2006 Year November 5, 2006 4a. Facility Name (if not institution, give street and number) 520 East Baltimore Street 5. Social Security Number 6. Sex 1/ X M 2 F 5. Social Security Number 6. Sex 1/ X M 2 F 5. Social Security Number 6. Sex 1/ X M 2 F 5. Social Security Number 6. Sex 1/ X M 2 F 5. Social Security Number 6. Sex 1/ X M 2 F 5. Social Security Number 6. Sex 1/ X M 2 F 5. Social Security Number 6. Sex 1/ X M 2 F 5. Social Security Number 6. Sex 1/ X M 2 F 5. Social Security Number 6. Sex 1/ X M 2 F 5. Social Security Number 6. Sex 1/ X M 2 F 6. Sex 1/ X M 2 F 5. Social Security Number 6. Sex 1/ X M 2 F 6. Sex 1/ X M 2 F 7. Age (In yrs. last birthday) 1/ X M Days Hours Min. 01/20/1954 6. Sex 1/ X M 2 F 7. Age (In yrs. last birthday) 1/ X M Days Hours Min. 01/20/1954 6. Sex 1/ X M 2 F 7. Age (In yrs. last birthday) 1/ X M Days Hours Min. 01/ 20/1954 F 6. Sex 1/ X M 2 F 7. Age (In yrs. last birthday) 1/ X M Days Hours Min. 01/ X M Days Hours Min. 01/ X M 01/ X		1- For State Registrar	Certificate of	f Death	Reg. N	. 200	6 363
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21. Signatury of Funeral Service Losshee 22. Signatury of Funeral Home 13.6 East Baltimore Street Tanceytown, Md. 2178 32.6 Part I. Erher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. List only one cause on each line immediate Cause (Final disease) and intraoral guishot wound one cause or each line immediate Cause (Final disease) and intraoral guishot wound one to the cause of death of the complete of	D36 thin 72 hour ne than "nate ledical Exan	Elementary/Secondary (0-12) College (1-4 d	during m	ost of working life. DO NOT use ref	ired) Ch	narter bo	•
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Failure List only one cause on each line Server Onset arm Death	A 2	Alan C. Farin	13	6 East Baltimore	Street 1	laneytown	
Due to (or as a consequence of): The production of the producti	/Medical	failure. List only one cause on each line Immediate Cause (Final disease a. Intraoral guns	hot wound				
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Pending Investigation Size and Accident Suicide Suicide Accident Suicide Accident Suicide Suicide Accident S	Viting this control of the side of the sid	1 Yes 2 No					Scene
296. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 5, 2006 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ion of trending P leath ror: After r the funera	1 Natural 5 Pending FOUND: Da	y,Year) FOUND:				
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Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ž		P			,	
	15	Tasha Greenberg MD. Assistant Med	ical Examiner 111	. 0	D 21201		

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of			giene Reg. No. 2006	36316
			Decedent's Name (First, Middle, Last,)				2. Date of De	ath	3. Time of Death
	Physici /Medic		William Joseph	Hall				October	27, 2006	6:53 P [™]
}	Examin		4a. Facility Name (If not institution, give			4b. City, Town,		Death	4c. County of Dea	
			Southern Maryland			Clir		M Hrs. Lo. D (B)	Prince (X
	Funeral Director		5. Social Security Number 6. Se 10	X 0 M 2□F /.	Age (In yrs. last birthday Yrs.	Months Days		Min. 8. Date of Bird (Month, Da	y, Year) C	thplace (State or Foreign ountry) 11 and
	ס		Usual Residence of Decedent					pune 30	, 1520 Mai	
	anylan show	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f	ecto	Maryland Prince (George's	Br	andywine				
	with t	Funeral Director	10e. Street and Number 13119 Martin Road			10f. Zip Code	20612	,	10g. Citizen of What C	
	ns 23	era	13119 Marital Status	12. Was Decede	ent Ever in U.S. 13.	Was Decedent of	20613 Hispanic Orig	in? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Am-	
9	or itar	Fun	1 ☐ Never Married 2 Married	Armed Force	□No	If Yes, specify Cul		Puerto Rican, etc.)		
93	ours ours	dby	3 Widowed 4 Divorced	If Yes, Give Year or Date	es:	1 Yes 2 A No	Specify:		Specify:	White
2	filed within 72 hours after death with the Maryland Hygiene. the than "natural", or itams 23s or 28s-f show ort, it a Micalical Examination is a notified at	Completed	15. Decedent's Edu (Specify only highest grad		(Giv	edent's Usual Occu be kind of work done DO NOT use retire	during most	of working	16b. Kind of Business	/Industry
2	withir ene. then	dmo	Elementary/Secondary (0-12)	College (1-4	Heavy		,	rator	Construction	n Excavation
5	illed Hygi other	e C	17. Father's Name (First, Middle, Last)		neavy	Equipmen		's Name (First, Middle,		JII EXCUVACION
Baltimore, Maryland 21215-0036	uld be Menta rked	To Be (Percy Allen Hall				Amin	ette Dorot	hy Boswell	
an	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene. Instruction: If Item 27 is marked other than "natural; or itams 23a or 28a-1 show any injury or other traumatic avent, It is Marilial Examination mail to a notified at ODGs.		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mail	ing Address (Stree	t and Number	or Rural Route Number	er, City or Town, State,	Zip Code)
<u>ک</u>	l and feelth im 27 her tr		<u>Catherine Hall - V</u>	life				Brandywine,		T Chat-
ŏ	Pages 1 nent of H nnt: If Its ury or ot		20a. Method of Disposition 1 Description 2 Cremation 3 Description		ate 20b. Place of Disp		li li		20c. Location - City or	
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Ba	Deperiment of the series of th		Hack A- Will		01240				ld Washingt 6, Waldorf	
			23a. Part1. Enter the disease, or compl	ications that cau	sed the death. Do not er					Approximate Interval Between
	Physician		shock, or heart failure. List only o Immediate Cause (Final disease or condition	Man	a a m dix	1 To	Sa	-		Onset and Death
	/Medical		resulting in death)	Due to (or	as a consequence of):	1 -1 00	7 /17 6	- 1		- // 9
П	Examiner		Sequentially list conditions,	184	pestous	Dr				Year
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (di	as a consequence of):					
•	xecut al-tran	хап	that initiated events resulting in death) Last	Due to (or	as a consequence of):		····			
8760,	The law requires that the death certificate be executed ite has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	aiE		4						
မ	tificati g phy as the	Physician/Medicai	_							
Вох	th cert endin r use	an/N	230. Was decedent pregnant		me of pregnancy h 2 Petal death 3	□Ectopic pregnand	37		23d. Date of de	,
о В	e dea he att	sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nt at time of death 5	Other (specify)			Month	Day Year
<u>о</u> .	d by t	Phy	Part II. Other significant conditions co	ntabuting to dear	th but not resulting in the	radorhijas opuņo s	woo in Part I	23a Did t	obacco use contribute to	the cause of death?
ds,	w requires that the death certific been signed by the atlending p should be detached for use as	d by	1 active significant containing so		an but not resulting in the		venin ratti.			robably 4 Unknown
Sor	w requ been shoul	ete						24a. Was		utopsy findings available
Re	he lav e has	Completed						autop perfo	rmed? prior to death?	completion of cause of
ta	iiclan: Th certificate rector, pag	a	25. Was case referred to medical				26 Place	1 ☐ Yes of Death (Check only o	2 No 1 □ Yes	2 □ No
>	ysici is cer direc	ToB	examiner?	lospital: 1 🗆 Inp	patient 2 ER/Outpatie	nt 3 DOA			dence 6 ☐Other (Spe	ocify)
0	Attending Physician: r death. sctor: After this certifice by the funeral director, t		27. Magner of Death 1 Natural 5 Pending	28a. Date of (Month,	Injury 28b. Time (of 28c. Inju			now injury occurred	
sio	ttendii death. xtor: A	cati	2 Accident investigation 3 Suicide 6 Could not be]Yes 2□N			
Division of Vital Records,	I or Attance after death Director:	Certification:	4 Homicide determined		f Injury - At home, farm, s , etc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tov	Street and Number or R vn, State)	ural Route Number,
_	To the Host train or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1. Certifying Phy	sicien: To the b	est of my knowledge, dea	th occurred at the t	me, date and	place, and due to the	cause(s) and manner a	s stated.
	ne Ho ne Fu	edical	(Check only 2 Medical Exami one)	ner: On the bas and manne	is of examination and/or in	nvestigation, in my	opinion, death	occurred at the time,	date and place, and du	to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	× 4 /		29c. Licen	se number		29d. Date signed (Moni	th, Day, Year)
			J-Romasi	IFIC	lason no	A D	0019	123	Oct 28	2006
	A Lat	1	30. Name and address of person who co	ompleted cause	of death (Item 23a) (Type	, Print)	Moorie	MA	2574	
			31. Date filed (Month, Day, Year)	32 P	gistrar's Signature	4	900		Vec1	
	Sta Registr		OCT 3 0 2	2006	we It is	port				

DHMH 17 Rev 1/2001

Registrar

OCT 3 1 2006

State of Maryland / Department of Health and Mental Hygiene 36318 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 30, Dorothy Kathleen Hoover 2006 1941 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Harford Havre de Grace If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 578-20-8842 86 Yrs. Director Dec. 3, 1919 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other then "netural", or Iteme 23a or 28a-f eho vent, the Medical Examinar must be positived at Maryland Cecil 1 XYes 2 No Directo Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 451 Susquehanna Avenue 21903 U.S.A. Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "netural", or 1 ☐ Yes 2 🖾 No δ Specify: Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Homemaker Personal Residence permit. Pages 1 and 2 should be tilt Department of Heelth and Mental Hy Important: If Item 27 is marked oth eny liury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James M. Chilton Eloise Livingston Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria H. McCrackan (Daughter) 2003 Flintwood Drive, Richmond, Virginia 23238 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Harford Memorial Gardens 11/04/06 4 ☐ Donation 5 ☐ Other (Specify) Aberdeen, Maryland 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A.
Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Multiple system **Physician** /Medical Due to (or as a consequence of) Examiner Shac 410 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificete 1 Yes WNo 25. Was case referred to medical examiner? Be 26. Pface of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2. No Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending 5 Pending 1 Natural Injury death 1 ☐ Yes 2 ☐ No investigation 2 Accident I Director: d in by the 3 Suicide 6 ☐ Coufd not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral DI completely filled in 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and H 55222 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Have De Grace aul S. UNION Little 501 Ave 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death A 2. Date of Death **Physician** Month 2006 Ossie Hayward October /Medical Acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Medical Center 1 D'Corrico REGIONAL Teninsula If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 2,1924 Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 ☐ ¥F NC 82 239-32-7742 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director VΆ Temperanceville 10e. Street and Number 10g. Citizen of What Country? 26128 Saxis Road 23442 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black ρ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry t of Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Bank Clerk Banking permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othen properties of the traumatic event 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (Robert H. Yarborough Emma Yarborough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Byrd /daughter 26128 Saxis Road, Temperanceville, VA 23442 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rolling Green Mem Park 11/3/2006 West Chester, PA 21. Signature of Funeral Service Limins 22. Name and Address of Facility
Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory failure **Physician** /Medical Due to (or as a consequence of): Examiner Preumonia Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of). Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Hypoglycemic encepholopathe Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) ed by the a detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Mellit 1 Yes 3 Probably 4 Unknown page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? (ormarhes certificate 1 ☐ Yes 2 ☐ No 1 Tes 2 410 Be 25. Was case referred to medical examiner? funeral director. 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 - Inpatient 2 ER/Outpatient 3 DOA Sig. 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After I Certification; 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the th Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H006453 30/FE 101 0.C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1008 CHILCH St. Salisbury Mel Michael I ELD FE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 3 0 2006 Registrar

		•	1 - For State Registrar	State of Marylan	d / Depa		t of H	ealth a		ental Hygi	ene	006	36320
			Decedent's Name (First, Middle, Last)							2. Date of Deat	1	V	3. Time of Death
	Physici /Medi		Margaret E. H	anna						Month Novembe	Day er 7	Year 2006	09:01 a ^M
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or	Location o	f Death			inty of Death	
			GREATER BALTIMORE	E MEDICAL CENT	ΓER	TOWS						LTIMOR	
	Funeral		5. Social Security Number 6. Sex 215-18-3604	W 0X C	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day, March 6,	Year)	9. Birthr	place (State or Foreign
	Director		Usual Residence of Decedent	94	115.					March 6,	1912	Mary	yland
	land		10a. State 10b. County	10c. Cit	y, Town or Le	ocation							10d. Inside City Limits
	Man	to	MD Baltimo	ore Wh	nite :	Hall							1 ☐ Yes 2X No
	iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Heelth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	Funeral Director	10e. Street and Number 1948 White Ha	ll Road		10f. Zip	Code 211	61		10	g. Citizen	of What Cou	ntry?
	ms 2	era		12. Was Decedent Ever in U.	S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Ameri	
9	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 Yes, spec			, Puerto i	Hican, etc.)		Black, White,	eic. nite
ဗ္ဗ	ral',	d b	3 X Widowed 4 □ Divorced	Year or Dates:		1 105	2 A . NO	зр о спу.			Spe	ecify: W.T.	
<u>ئ</u>	72 h 'natu	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa rk done d	tion u <i>ring</i> most	of workii	ng	6b. Kind o	of Business/In	dustry
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2	filed y Hygie Sther 1		17. Father's Name (First, Middle, Last)		Car	e cer.	La M			(First, Middle, A			V 100
an	d be ental	To Be	Benjamin Frank	lin Stiffle	er					et Fran			er
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Ie marked other than aumatic event, the Ma	ř	19a. Informant's Name/Relationship (Ty)			ng Address	(Street a	nd Numbe	r or Rura	l Route Number,	City or To	wn, State, Zip	Code)
	and 2 Belth a n 27 io		Dorothy E. Pearce	/ Daughter	194	8 Whi	ite	Hall	Rd	., Whit	е на	all,MI	21161
re,	s 1 and 2 if Heelth item 27		20a. Method of Disposition		lace of Disponentery, cre				D	ate :		on - City or To	
Ë	Page nent o nt: If		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Vē	rnon hodis	Unit t Cen	eter	$\mathbf{v} \stackrel{L}{:}$	2006	10,	Whit	e Hal	1, MD
Baltimore,	permit. Pages of Depertment of Findportant: If Ite any injury or of office.		21. Signature of Funeral Service License		. 2	2. Name an	d Addres	s of Facility	у Ј.				tuary, Inc 7349
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat								T	Approximate Interval Between
	Physician	V 3	Immediate Cause (Final	lo cause on each line.		1 1	1					1	Onset and Death
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	B =	ner	Securations list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a / nseq	uence of):								
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
760,	oe ex		1930king in Godin) Last	Due to (or as a conseq	uence of):								
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9 ×	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregna	incv						201	Date of deli-	
Вох	thet the death cer ed by the attendin detached for use	lan	in the past 12 months?	1□Live birth 2□Feta 4□Pregnant at time of d	Ideath 3[☐Ectopic pr☐ Other (sp					230.	Month	ery Day Year
o	the de	ysic	1 □ Yes 2.20No 9 □ Unknown	9□ Unknown	eau St	T Offier (2b	ecity)						
P.0	es thet t Igned by be detai	'Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	underlying c	ause give	n in Part I.		23e. Did tob	acco use o	contribute to t	he cause of death?
of Vital Records,	uires sign	d by	thrombo	esis of	righ	+ 16	DWE			1 ☐ Ye	s 2 N	o 3 ☐ Prol	oably 4 Unknown
Ö	w requir been sl should	Completed	ox+soi	w.+u						24a. Was a	24	4b. Were auto	opsy findings available
Be	he lav e has	Ę	e KITE	7						autops perforn	ed2	prior to co death?	mpletion of cause of
ā		Ö	25. Was case referred to medical					26 Place	of Death	1 Yes 2	No No	1 🗆 Yes	2 L No
>	Physiclan: this certific ral director,	ToB	examiner?	lospital: 1 patient 2 -	ER/Outpatie	nt 3 DC	Othe	APT.		ne 5 Reside		Other (Speci	(v)
9	ig Phys ter this neral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury Work			28d. Describe ho			,,
<u>6</u>	ndin ath. r: Aft	atio	Natural 5 Pending 2 Accident investigation	(Worth, Day 16ar)	Injury	М		res 2 🗆 1	No				
Division	or dei	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif		reet, factory	y, office		- 1	28f. Location (Sti City or Town		umber or Rura	al Route Number,
٥	rs eft al Di	Certification:								,	/		
	To the Hospital or Attending Ph within 24 hours eiter death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only 2 Medical Examination)	sician: To the best of my kno ner; On the basis of examina and manner stated.	wledge, deal tion and/or in	th occurred nvestigation	at the tim , in my op	e, date and inion, dea	d place, a th occurre	and due to the ca ed at the time, da	use(s) and ate and pla	d manner as s ce, and due t	stated. o the cause(s)
	within To th comp	×	29b. Signature and title of certifier	Ω		290	. License	number		25	d. Date si	gned (Month,	Day, Year)
	_		Mach Ston			0	00	580	82	_	11/	7/06	
	h		30. Name and address of person who co	impleted cause of death (Item	n 23a) (Type	Print)		7 - 1		-	- /	112	0/20//
_	J		Mark Gosne	11 6535	Ne Cl	narle	5	Wite	55	0 lon	SON,	110:	21204
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	7.00					/		•
	Regist	rar	NOV 1 5 20	Ub Marc.	All h	P.S.	-						

ORIGINAL

	1	For State Registrar	State of Maryland		artment of tificate of			iene .s. No.2 0 0 6	36321
Physician	1	1. Decedent's Name (First, Middle, Las THOMAS DAVID	JOHNSON				2. Date of Death OCTOBER	29 2006	3. Time of Death 1:00 P M
/Medica Examine		4a. Facility Name (If not institution, give 23311 WOODFIELD R				or Location of Dea		4c. County of Deat	h
Funeral Director		5. Social Security Number 6. Se		st birthday) Yrs.	If Under 1 Yea Months Day	r If Under 24 Hr		Year) 9. Birt	hplace (State or Foreign untry)
D	<u>}</u>	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo					10d. Inside City Limits
he Mary	Director	Md. Montgo	omery			nsville		Og. Citizen of What Co	1 Tes 2 No
th with t	20	10e. Street and Nu <i>m</i> ber 23311 Woodfield F	Road		10f. Zip Code	0882		United St	•
35 us after dea ur, or iteme	Dy Funeral	11. Marital Status 11⊠ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 274 No If Yes, Give Year or Dates:		Vas Decedent of f Yes, specify Cu I ☐ Yes 2 N		Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White Specify: WI	
	Completed	15. Decedent's Ed (Specify only highest gra		(Give . life. [lent's Usual Occ kind of work don DO NOT use reti	e during most of wo red)	orking	16b. Kind of Business/	Industry
be filed hall Hyging of other event,	lo pe Co	12 17. Father's Name (First, Middle, Last) Unknown		NOI	ie – Dis		ame (First, Middle, M		
2 9575		19a. Informant's Name/Relationship (7 Sandi Johnson/Add						City or Town, State, 2 ville, Md.	Tip Code) 20882
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2 eny Injury or other page.		20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State cen	netery, cren	sition (Name of natory or other p itan Cre	1	Date 2	20c. Location - City or Alexandria	
Baltimo permit. Pages Department of Important: If I ony Injury or pnce.	1	21. Signature of Funeral Service Licen	V. Barber	22			r Funeral	Home ville, Md.	20882
Physician		23a. Part1. Enter the disease, or companies that the shock, or heart failure. List only immediate Cause (Final disease or condition	plications that caused the death. one cause on each line.	Do not ente					Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):	J FA	144			
60, be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseque						
\$8760, icate be elphysician s the buria	alcai	· ·	. d						
Records, P.O. Box 68760, The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Pnysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3	Ectopic pregnar Other (specify)	icy		23d. Date of del Month	ivery Day Year
rds, P.	2	Part II. Other significant conditions o	ontributing to death but not result	ing in the ur	nderlying cause (given in Part I.	23e. Did tob	eacco use contribute to	the cause of death?
The law requires that has been signed as been signed as be a should be considered.	Completed						24a. Was ar autops perform 1 ☐ Yes 2	y prior to o ned? death?	topsy findings available completion of cause of
f Vital Re systelen: The is certificate hadirector, page	ů Q	25. Was case referred to medical examiner?	Hospital:			\the a a	eath (Check only one	9)	
O ₹ = ª ,	Mon: 10	27. Manner of Death 1 No Naturaf 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	R/Outpatien 8b. Time of fnjury	28c. In	4 🗆 Nulsing	Home 5 Reside	nce 6 Other (Special occurred)	cify)
Division (To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At homo building, etc. (Specify)	e, farm, stre	eet, factory, offic	е	28f. Location (St. City or Town	reet and Number or Ru , State)	oral Route Number,
Hospi 4 hour Funer tely fill	Medical C	29a. Certifier 1 A Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge: On the basis of examination and manner stated.	edge, death in and/or inv	occurred at the vestigation, in my	time, date and place opinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
To the within 2 To the comple		29b. Signature and title of certifier			i	nse number		9d. Date signed (Monti	h, Day, Year)
•	1	30. Name and addr ss of person who MAUNES M. Pr	completed cause of death (Item 3	3a) (Tune	Print) MA	105276	LOAN I	MEDICA	U (a
		MAUNEW M. P.	TENSEN, M.T)	WA	ATINGTO	N.DC	20307	
State Registra	е	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	Te Con	de				

				1 - State of Maryland / Dep Registrar Ce	artment of F			20	0.0	26222
				Decedent's Name (First, Middle, Last)	ranoate or	Dealit	2. Date of Deat		UO	3. Time of Death
		Physic /Medi		Marshall Elliott Jacobs			October	27, 2	006°	8:18PM M
	a.	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	or Location of Death		4c. Count	y of Death	I
				Suburban Hospital	Bethesd			Mont	gomer	У
	L	Funeral Director		5. Social Security Number 577-28-7964 6. Sex 1 ☑ M 2 ☐ F 83 Yrs.	Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day, 1-13-19		9. Birthp Goun	lace (State or Foreign try) ngton, DC
				Usual Residence of Decedent			1 13 13.		, abiii	ngcon, -
		arylar show	_	10a. State 10b. County 10c. City, Town or Lo	ocation	-			1	0d. Inside City Limits
		Ba-f	Director	MD Montgomery Chevy Ch	ase					1⊠Yes 2□No
		with ti		10e. Street and Number	10f. Zip Code		11	0g. Citizen of		try?
		eath	erai	7300 Lynnhurst Street 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20815			U.S.		
	10	fter d	Funeral	1 Never Married 2 Married 1 Never Married 2 Married 2 No	If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	Rican, etc.)		ce - Americ ck, White, e	
	21215-0036	orrs a	٥		1 ☐ Yes 2 🔼 No	Specify:		Specif	y: Whi	te
	5-0	72 hc	Completed		dent's Usual Occup	ation during most of workii		16b. Kind of B		
	121	Mithin Ne.	ğ	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired	1)	ng .			
		lled v Hygie ther t		12 Hom 17. Father's Name (First, Middle, Last)	e builder			Privat		
	Maryland	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It is marked other then "neturel", or iteme 23e or 28esf ehow traumatic event, it a Modical Examination to indiffed a	o Be	Louis Jacobs		18. Mother's Name	Bergazir		ne)	
	Z	should Me Me mark	ို		na Address (Street	and Number or Rura			Ctata Tia	Codel
		5 E Z E				st St. Che				C008)
	ore			20a. Method of Disposition 1 🗵 Burial 2 □ Cremation 3 □ Removal from State	sition (Name of natory or other plac	(e) D	ate 2	20c. Location	City or Tox	wn, State
	Ě	Find the second		4 Donation 5 Other (Specify) Garden of			-06	Clarks	ourg,	MD
9	Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Fune al Service Licensee 22	Denzansk 170 Rockv	yoʻ©⊎Mber ville Pike	g Memori Rockvil	ial Cha lle, MT	pels,	Inc.
2/06				23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying					Approximate Interval Between
2	,	Physician		Immediate Cause (Final disease or condition COTONARY AFTERY D	isease					Onset and Death
0		/Medical Examiner		resulting in death) Oue to (or as a consequence of):						
00			7	Sequentially list conditions, * any, leading to intradiate b						
328		t the d	E I	cause. Enter Underlying Cause (Disease or injury						
20	o,	cate be executed physician and the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):					-	
	68760,	cate be ex physician the buria	dicai	d						
	89	9 14 14	Med	IF FEMALE:						
	Вох	eath certifi attending for use as	an/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy				e of deliver	у
2	0.	es that the death igned by the atte be detached for	by Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown 9 Unknown	Other (specify)			Мо	nth [Day Year
2	<u>α</u>	es that thighed by	Ph	Part II. Other significant conditions contributing to death but not resulting in the ur	derhina cause ans	on in Part I	23o Did tob	2000 1100 0001	ib	
Secob	Division of Vital Records,	The law requires that the death certifi te has been signed by the attending page 2 should be detached for use as	d b	Adenocarcinoma Lung	loonying cause give	eritiranti.				cause of death?
YY.	Ö	w requir	iete				24a. Was an	-		
=	Be	ding Physicien: The lav h. After this certificate has funeral director, page 2	Completed				autopsy perform	ad?	vere autop: prior to com leath?	sy findings available pletion of cause of
Murshall	ita	icien: Th certificate ector, pag	BeC	25. Was case referred to medical		26. Place of Death	1 ☐ Yes 21	No 1	☐ Yes 2	!□ No
3	>	Physicien: this certific ral director.	ToB	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatien	t 3□ DOA Othe				or (Specify)	
3	0	Jing Pl		27. Manner of Death 1 ⊠Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) Injury	28c. Injury Work		8d. Describe how			
	sio	Attending r death.	cati	2 Accident investigation	M 1 □ Y	res 2 □No				
	Σ	or At after d Direct in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	et, factory, office	28	Bf. Location (Stre City or Town,	et and Numbi State)	er or Rural i	Route Number,
	_	Hospital		29a. Certifier 11 Certifying Physician: To the best of my knowledge, death						
		To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death control of the basis of examination and/or invaries. On the basis of examination and/or invaries, and manner stated.	estigation, in my op	e, date and place, ar inion, death occurred	d at the time, dat	ise(s) and ma e and place, a	nner as stat and due to t	led. he cause(s)
		To th To th Comp	X	29b. Signature and title of certifier	29c. License	number	290	d. Date signed	(Month, Da	sy, Year)
	11	0	-	Thus (Hellen	DC 549	96		10-29-	06	
_	1	·		30. Name and address of person who completed cause of death (Item 23a) (Type, F						
				Michael A. Newman Suite 404 2021 K St		Washingtor	ı, DC			
		Sta Registra		31. Date filed (Month, Day, Year) OCT 3 1 2006 Registrar's Signature	Les .					

			riease	State of Ma	ryland / Dep			-	_	
			For State	State of Ivia	-	rtificate of			9. No 2 0 0 6	36323
			Registrar 1. Decedent's Name (First, Middle, Las	t)		rimoato or	Douth	2. Date of Death		3. Time of Death
	Physicia /Medic		JESTINA	*	JOHNSON			October	27,2006 Year	1330 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death	1	4c. County of Death	
			Montgomery Genera	a1		01ney			Montgomer	
	Funeral		5. Social Security Number 6. S	7. Age	(In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
	Director		217-49-5435	82	, 115.			Jan 1,19	924 Lib	eria
	and and		10a. State 10b. County		10c. City, Town or Le	ocation				10d. fnside City Limits
	Mary f sh	ច	Md. Montgome	3477	01ney					MXYes 2 □ No
	r 28a	Director	Md. Montgome	=1 y	Office	10f. Zip Code		10	ng. Citizen of What Cou	ntry?
	3a o		18603 Sun Haven	ourt		208	32		11.5	Δ
	death	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.		Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Race - Ameri	
ဖွ	after or ite	by Funerai	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No)	1 ☐ Yes 2 ☑ No		o riican, etc.)	Specific D 1	
ဋ္ဌ	urel',		3√2 Widowed 4 □ Divorced	Year or Dates:		100 200110			Specify: Blad	2K
<u>5</u>	filed within 72 hours after death with the Maryland Hygiene. sther then "neturel", or items 23a or 28a-f show ent, the Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de <i>completed)</i>	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of Business/Ir	dustry
7	withir then then	E G	Efementary/Secondary (0-12)	College (1-4or 5+)		0)		Determina	
20	Hygie ther int, II		10th 17. Father's Name (First, Middle, Last)		Hous	ewife	18. Mother's Nan	ne (First, Middle, M	Private Maiden Sumame)	
an	d be ental	o Be	Louis B. Crayton				Sarah S		,	
₹	shoul nd Me	2	19a. Informant's Name/Relationship	ype, Print)	19b. Maili	ng Address (Street			City or Town, State, Zij	o Code)
Z	nd 2 :: lith ar 27 is r tre.		Nathaniel Massaque	oi/Great Ne	phew 1860	3 Sun Ha	ven Court	, 01ney 1	Md. 20832	
ē,	s 1 a f Hea item othe		20a. Method of Disposition		20b. Place of Dispo				20c. Location - City or T	own, State
E	Page nent c nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			Heaven Co	1	1/06	Silver Spri	ng, Md.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Figureral Service Licen	see	2	2. Name and Addre	ess of Facility	hnson &	Jenkins Inc	
<u>ш</u>	8058				71	6 Kenned			D.C. 20011	•
п			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do not en	ter the mode of dyi	ng, such as cardiad	or respiratory arre	est,	Approximate Interval Setween
	Physician		Immediate Cause (Finat disease or condition	. Meta	Static	Aden	ocarci	noma	_	2 Weeks
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
	ZXXIIIIII	<u>.</u>	Sequentially list conditions,	b. Due to (or as a	consequence of):					
	ted	Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	240 10 (0) 45 4	0011004001100 01).					
	be executed icien and burial-transit	Exai	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
760,	te be executed ysicien and ie burial-transit	ä	(d						
68	death certificat e attending phy d for use as th	Medi	IC CCIALLE							
Вох	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		Ectopic pregnanc	v		23d. Date of deliv	,
O. E	res thet the death certificate igned by the attending phys be detached for use as the	Physician/Medi	in the past 12 months? 1 □ Yes 2 BNo 9 □ Unknown	4☐Pregnant at ti 9☐ Unknown	me of death 5(Other (specify)			Month	Day Year
<u>o</u> .	d by letach		Part II. Other significant conditions o	natributing to death but	not resulting in the	andortving cause an	on in Part I	23e Did tob	acco use contribute to	he cause of death?
ds,	The law requires thet the site has been signed by the bage 2 should be detached.	d b	Hugertensi	(v)	Thou rooding in the	indonying oddoo gr	voir in tracti.	1 ☐ Ye		1
Vital Records,	w require s been sig should b	Completed	21-1-105	CIT				24a. Was ar	245 144	findings and labe
Rec	has ye 2	m	Diabetes					autopsy	prior to co	opsy findings available empletion of cause of
a		င္ပ	25. Was case referred to medical				00 Bl (D	1 Yes 2	•	2□ No
₹	ding Physician: The lav h. Atter this cartificate has funeral director, page 2	To B	examiner?	Hospital: 1 Departies	t 2 ER/Outpatie	nt 3 DOA Ott	ner .	th (Check only one	nce 6 ⊡Other (Speci	6.0
ō	Phy Prthis erato		27. Manner of Death	28a. Date of Injury	28b. Time o	of 28c. Inju	ry at	28d. Describe ho		(1)
0	Attending Physician: r death. ector: After this cartification the funeral director.	atlo	Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	M 1 □	Yes 2 □No			
Division of	l or Attan eftar deatl Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Pface of Injur	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (Str. City or Town	reet and Number or Run , State)	al Route Number,
	Hospital or 24 hours efta Funeral Dir tely filled in								·	
	To the Hospital or Attance within 24 hours effar death To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ninar: On the basis of e	examination and/or in	th occurred at the to execution, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as s ite and place, and due t	stated. o the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier	and manner state	o u.	29c. Licen	se number	29	Pd. Date signed (Month,	Day, Year)
	2 3 2		No All Marie	So Dun	101010	1 62	168		10/20/	010
1	X		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	Print)	00		120/	04
4			Shuam Park	nie Mi	181011	Prince Pi	millip D	r Ola	eu MD :	20832
	Sta		31. Date filed (Month, Day, Year) OCT 3 1 2006	32. Registrar	's Signatur	7				
	Registr		111 1 14 1 /11/17)	Pro I		•				

			For State Registrar		State o	f Marylan		artment of I				ene 3. No.2 0 0 6	36324
ô¢.	Physic /Medi		1. Decedent's Nam	e (First, Middle, I David	Jones					M	ate of Death onth Dember	Day Year 5, 2006	3. Time of Death 8:14 A M
	Exami		4a. Facility Name (ive street and nur	,		4b. City, Town,				4c. County of Dea	th
	Funeral Director		24540 Ca 5. Social Security N 111-24-7	1507 6		7. Age (In yrs. 76	last birthday) Yrs.	Dena If Under 1 Year Months Days	If Under	24 Hrs. 8. Da Min. 7(M	ate of Birth lonth, Pay	Carolir (9ar) 9. Bin Co	thplace (State or Foreign ountry) N. 4.
	ow ##		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	e Mary	ctor	MD	Carolir	e	Dena	ton						1 ☐ Yes 2 ☐ No
	ath with th	ral Dire	10e. Street and Nu		louse All	ley		10f. Zip Code 21 629)		100	g. Citizen of What Co USA	puntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "natural", or items 23a or 28e-f show important: if item 27 ie marked other then "natural", or items 23a or 28e-f show applyingny or other traumatic event, the Medical Examinat must be motified at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Marr 3 ☑ Widowed	ied 2∐ Married 4 ∐ Divorced	Armed Fo	2 No 1061		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛱 No			es or No- etc.)	14. Race - Ame Black, Whit Specify: Cau	e, etc.
2-0	"natur	eted	(Spec	15. Decedent's city only highest of	Education rade completed)		(Give	dent's Usual Occu kind of work done	durina mos	at of working	16	6b. Kind of Business	Industry
7121	within jiene. r then	Completed	Elementary/Seco	ondary (0-12)	College (1	-4or 5+)		DO NOT use retire LOPEN	ed)		1	Real Easta	ite
Maryland 21215-0036	unid be filed Mental Hyg arked othe	To Be C	17. Father's Name John W	(First, Middle, La Liley Jo			Deve			er's Name (First Pen Luci		,	
Mar	d 2 sho th and 7 le mu traum		19a. Informant's Na	,	(Type, Print) Daughte							City or Town, State, 2 New York	
Je,	of Heal		20a. Method of Disp	position		20b. P		esition (Name of matory or other pla		Date Date	-	oc. Location - City or	
Baltimore,	ment cant		4 Donation	5 Other (Spec		Jiaio	ipitol	Cremator	ry 1	1/6/200		over, Dela	
Bai	Depar Depar Impor eny in		Signature of Fu	ineral Service Lic	P M	are.	22	Name and Address	ess of Facili	Home, P	.A.		land 21629
			23a. Part . Enter the shock, or hea	he disease, or co	mplications that c	aused the death	n. Do not ent	er the mode of dy	<i>Secon</i> ng, such as	d Stree cardiac or respi	t, Der iratory arres	iton, Mary	Approximate Interval Between
198%	Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final	_ a		State	cance	er				Onset and Death
E	Examiner					or as å consequ	uence of):						
	ed sit	lner	Sequentially list confiant, leading to incause. Enter Under Cause (Disease or	nditions, Imediate orlying	b. Lue to (or as a cons u qi	uence of):				-		
Ć,	ate be executed hysicien and the burial-transit	Examiner	that initiated events resulting in death) I	•	c. Due to (or as a consequ	uence of):						
8760,	ate be ex hysicien the buria	dlcal			d								
Box 6	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 [months?		come of pregna irth 2 🗆 Fetal ant at time of de	ldeath 3□	Ectopic pregnanc Other (specify)	у			23d. Date of deli	ivery Day Year
P.O.	at the de by the e	hys	9 🗌 Unknown		9□ Unkno								
ords,	w requires that been signed be should be det	þ	Part II. Other signif	icant conditions	contributing to de	ath but not resu	ulting in the u	nderlying cause giv	ven in Part I	. 23		2 No 3 Pro	the cause of death? obably 4 \(\bigcap \text{Unknown}\)
		Completed								_	a. Was an autopsy performe	d? prior to death?	topsy findings available completion of cause of
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ysicien; Th is certificate director, pag	o Be	25. Was case reference examiner? 1 Yes 2 3		Hospital:	npatient 2 🗆	ER/Outpatien	. 20 pos Ot		of Death (Chec			
ion of	Jing Ph J. After th funeral	atlon: To	27. Manner of Death 1 Natural 2 Accident		28a. Date of		28b. Time of Injury	28c. Injui	4 🗆 Nu	28d. De		ce 6 ☐ Other (Speciniury occurred	nty)
Divis	al or Attens s after deat if Director: ed in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place	of Injury - At ho ng, etc. (Specify	ome, farm, str	eet, factory, office		28f. Lo.	cation (Streety or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)	1 Certifying F	hysician: To the miner: On the ba and mann	isis of examinat	wledge, death tion and/or in	n occurred at the til vestigation, in my o	me, date an opinion, dea	d place, and due th occurred at th	e to the caus ne time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
)	To the within 2 To the comple	Σ	29b. Signature and	tifie of certifier	2			29c. Licens	se number	7	29d	Date signed (Month	
			30. Name and addr.	lintail	Drive	Suite	5,8	aston,	mo	21601		i.h	7
	Sta Registr		31. Date filed (Mon	th, Day, Year)	32. Re	egistrar's Signat	ture						
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							ORIGI	NAL					

			1 - State Registrar Amend It	State of em 26 pe	Maryland r verb.	d / Depa G86]	artment of H	ealth a d hh Death	ind Mer	ntal Hyg	iene 20(16	36325
			Decedent's Name (First, Middle, La							Date of Deat	th		3. Time of Death
	Physici /Medic		Waltrude B.	Jackso	n				0	Month Ctobe	r 29,2	006	8:47p M
	* Examin		4a. Facility Name (If not institution, gir				4b. City, Town, or	Location of	f Death		4c. County o	f Death	
			249 Shady Bead				North				Ceci		
	Funeral Director		220-50-1561	Sex 7 1 □ M 2 🖫 F	. Age (In yrs. Ia	**	If Under 1 Year Months Days	tf Under 2 Hours	Min.	Date of Birth (Month, Day, Druary	Year)	9. Birthpl Count Gerr	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Lo	cation					10	d. Inside City Limits
	Aaryli Feho	៰										1	1 ☐ Yes 2 🛣 No
	28a-	Director	MD Cecil 10e. Street and Number			E1kto	10f. Zip Code			1	0g. Citizen of Wi	nat Count	n/?
	3a or		464 Kirk Rd.				21921				U.S.		.,.
	death	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S	S. 13.	Was Decedent of Hi	spanic Orig	in? (Specify	Yes or No-	14. Race	- America	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23s or 28s-f ehow other traumatic event, the Madical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🙀 Divorced	Armed Ford 1 Tes 2 If Yes, Give Year or Dat	No No	1	f Yes, specify Cuba 1 ☐ Yes 2 2X No	n, Mexican, Specify:	, Puerto Ric	an, etc.)	Specify:	, White, e Whi	
5-0	72 ho	Completed	15. Decedent's E				dent's Usual Occupa		of working		16b. Kind of Bus	iness/Ind	ustry
2	within ene. then "	nple	Elementary/Secondary (0-12)	College (1-4	lor 5+)	life.	DO NOT use retired,)	ar working				
2	e filed within al Hygiene. I other then '	Cor	12			Admin	istrative				Sales		
and	be fill d ott	Be	17. Father's Name (First, Middle, Last								Maiden Surname)	
ž	2 should be and Mental is marked faumatic ev	P	Milford B. Sim			10h 14-85				e Stub			
Maryland	d 2 sl th and 17 is r traur		19a. Informant's Name/Relationship				ng Address (Street a						Code)
	s 1 and 2 f Heelth a Item 27 is other trac		John M. Jackson, 20a. Method of Disposition	Jr./Son	20b. Pla	ace of Dispo	Vew Bridge sition (Name of	SCHOOL ST	, Ris		n MD 2 20c. Location - C		vn, State
<u>o</u> u	eges ant of tt: If It		1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		ate Imm	metery, cret acula	natory or other place te Concep	tion I		ber 2,			
Baltimore,	permit. Peges 'Depertment of H Important: If Ite eny injury or of		21. Sign ture of Extrars Service Lice			meter	. Name and Addres		2006	5	Elkt	on,	MD
Ã	Depe Impo eny li		W 24.0				Andrew G.	Gee 1	Funera	al Home	е		
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that cau	used the death.	Do not ent	259 E Ma er the mode of dying	inSt. J. such as c	ardiac of re	spiratory arre	D 21921		Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	One cause on eac	im wh	am.	91						Onset and Death
	/Medical		resulting in death)	Due to (o	as a conseque	ence of):							1 4640
	Examiner		Surprentially list over-thisms	b									
	D #	Iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequ	ence of):							
	ecute and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (e.									
8760,	cate be executed physicien and ; the burial-transit	E		Due to (bi	r as a consequ	ence or):							
387		dlcal		_ d									
Box (res thet the death certificioned by the attending be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			-				23d. Date	of deliver	y
	death	icla	in the past 12 months? 1 □ Yes 2 ☑ No	4□Pregnar	h 2∏Fetalo nt at time of dea		Ectopic pregnancy Other (specify)				Mont	h [Day Year
P.O.	et the by th	hys	9 Unknown	9□ Unknow									
	The law requires thet the set hes been signed by th page 2 should be detache		Part II. Dther significant conditions	contributing to dea	th but not resul	ting in the u	nderlying cause give	on in Part I.				ute to the	bly 4 X Unknown
<u>0</u>	s been si should t	lete								24a. Was ar	n 24b. W	ere autop	sy findings available
æ	The lav	Completed							_	autops: perform	y pri ned? de	ath?	sy findings available pletion of cause of
ita	rtifice	BeC	25. Was case referred to medical					26. Place of	of Death /C	1 ☐ Yes 2		Yes 2	No
₹	nysic alis ce direc	To	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 _ tnp	oatient 2 🗆 E	P/Outpatier	t 3 DOA Othe	or: 4 🗆 Nurs	sing Home	्रोठ्रॉ तिह ाde	nce 6- ⊊ Other		Daughters
0	ng PI		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d	. Describe ho	w injury occurred	4	Residence
sio	eath. or: A	catl	2 Accident investigation	10			M 1 🗆 Y	′es 2 □ N					
Division of Vital Records,	el or Att s efter d bl Direct ed in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place o	f Injury - At hon , etc. (Specify)	ne, farm, str	eet, factory, office		28f.	Location (Str City or Town	reet and Number , State)	or Rural	Route Number,
^	To the Hospitel or Attending Physicien: The within 24 hours effer death. To the Funerel Director: Affer this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier 1 Certifying Pl (Check only one) 2 Medicat Example	hysician: To the b miner: On the bas and manne	is of examination	rledge, death on and/or in	occurred at the tim restigation, in my op	e, date and inion, death	place, and n occurred a	due to the ca	use(s) and mani ite and place, an	ner as sta d due to t	ted. the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	71			29c. License	number		29	d. Date signed	Month, D	ay, Year)
)			1 ac 11				05	247			11/6	106	
	5		30. Name and address of person who	1-	of death (Item	1	1	. (:		0		100	2 + 2 -2/4
			31. Date filed (Month, Day, Year)	DO POVI	jistrar's Signatu	SOUP	n Green	7 57	_	3altin	mare,	/ V >	21201
là	Sta Registr		NOV 1 6 2006	A D	K	Cornel							
			IAOA T A FOOD	1 of 10 10 10 10 15 15	The state of	Carlo Carlo							

,			State of Maryland / Department of Heal 1- State Registrer Certificate of Deal		ntal Hygien	2006	36326
ı	Physici		Decedent's Name (First, Middle, Last) LAURA JEAN KLINE	2.	Date of Death	ay Year,	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Washington County Hospital Hagers	ation of Death		c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U	Under 24 Hrs. 8. ours Min.	Date of Birth (Month, Day, Yea arch 14,	9. Birth	place (State or Foreign ntry) ryland
	farylend steri	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Washington Hagerstown				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the has or 28a-	Direc	10e. Street and Number 10f. Zip Code 14 Sturgis Street 21740	.	10g. C	Citizen of What Cou	•
36	2 should be filed within 72 hours after death with the Marylend and Mental Hygiene. Is marked other then "neturel", or items 23s or 28s-f show sumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married 2 Married 1 1 Yes 2 X No 13. Was Decedent of Hispan If Yes, specify Cuban, Me		y Yes or No- an, etc.)	U.S.A. 14. Race - Ameni Black, White, Specify: W	can Indian,
Maryland 21215-0036	within 72 hou ene. then "neture he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) N / A N / A		16b.	Kind of Business/Ir	dustry
land 2	be filed ital Hygi id other event, I	To Be Co		Mother's Name (F Elsie	irst, Middle, Maide May	·	nner
	D 5 5 5		19a. Informant's Name/Relationship (Type, Print) Elsie M. Moser Mother 11618 Pheasant				
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny Injury or other once.		20a. Method of Disposition 1	ry 10-		Location - City or To gerstown ,	own, State Maryland
Balt	permit. Departr Importi eny Inje		21. Signature of Funeral Service Licensee R. hoel brady Andrew K. Cof 40 East Antie	fiman Fun etam Stre	eral Home et, hage	e, Inc.	
	Physician	:	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	1	spiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of): Sequentially list conditions,				
o,	death certilicate be executed e ettending physicien and of for use as the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
68760,	titicate be ng physici as the bu	fedical	d				
P.O. Box	that the death certific led by the ettending p detached for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of deliv Month	ery Day Year
	w requires that the s been signed by th i should be detache	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Dawl) Jynduwu	Part I.	23e. Did tobacco	use contribute to t	he cause of death?
of Vital Records,	The la	Complet	Mariners Dewentia Myreiners Dewentia		24a. Was an autopsy performed?	prior to co	psy findings available impletion of cause of
f Vita	Physicien: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner?	Place of Death C		6 ☐Other (Special	(y)
Division o	ding h. After fune	Certification:	27. Manne Death 1 atural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	2 🗆 No	. Describe how inj		
Divi	lospital or At hours etter of unerel Directly filled in by	Certif	4 Homicide determined building, etc. (Specify)		City or Town, Sta		
	To the Hospital or Attenwihin 24 hours elter deat To the Funerel Director: completely filled in by the	ledicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, day one) Certifying Physician: To the best of my knowledge, death occurred at the time, day one one) Certifying Physician: To the best of my knowledge, death occurred at the time, day one one of the control of the best of my knowledge, death occurred at the time, day one of the control of the best of my knowledge, death occurred at the time, day one of the best of my knowledge, death occurred at the time, day one of the best of my knowledge, death occurred at the time, day one of the best of my knowledge, death occurred at the time, day one of the best of my knowledge, death occurred at the time, day one of the best of my knowledge, death occurred at the time, day one of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the best of my knowledge, death occurred at the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the best of my knowledge, death occurred at the best of my knowledge, death occurred at the time, day of the best of my knowledge, death occurred at the best of my knowledge, death occurred at the best of my knowledge, death occurred at the best of my knowledge, death occurred at the best of my knowledge, death occurred at the best of my knowledge, death occurred at the best of my knowledge, death occurred at the best of my knowledge, death occurred at the best of my knowledge, death occurred at the best	n, death occurred	at the time, date a	nd place, and due t	o the cause(s)
)	with To	×	29b. Signature and title of certifier 29c. License num H 806			ate signed (Month,	
3	H-3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	E Anti	elan s	31740	1,2006
	Sta Reg istr		31. Date filed (Month, Day, Year) OCT 3 1 2006 32. Registrar's Signature		,		

			Please	Type or Print in E				•		•	
			1 - For State Registrar	State of Marylar	•	tment of F ficate of i		Mental Hy	gienę Reg. No.	ואחה	36327
20	Dhuaisi		Decedent's Name (First, Middle, Las	"		50		2. Date of De			3. Time of Death
	Physici /Medio	al	DAVID WILL	IAM KEN	21010	OK.	I continue of Depart	OCTOBE	R 3	1 2006	0035 M
-3	Examir	er	4a. Facility Name (If not institution, give +HE MEMORIA	//		b. City, Fown, or	AS TON		40.	County of Death	
	Funeral Director		5. Social Security Number 6. Se		last birthday)	f Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y Year	9. Birth	place (State or Foreign intry)
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ly, Town or Locat	tion					10d. Inside City Limits
	ges 1 end 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If Itam 27 is marked other then "natural", or Itams 23a or 28s-f show or other traumatic avant, Ita Madical Examinar must be notified at	Funeral Director	MD CARO	LINE PR	ESTON	10f. Zip Code			10g. Citi	zen of What Cou	1 Tyes 2 No
	23a or	rai Di	22712 MARS		RD.	216	55		U	SA	
	itams Itams	-une	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	.S. 13. Was	s Decedent of H es, specify Cuba	ispanic Origin? (Si in, Mexican, Puerl	pecify Yes or No o Rican, etc.)	>-	 Race - Ameri Black, White 	
5-0036	72 hours after natural', or ita iical Exemina	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 🗆	Yes 2 No	Specify:			Specify: ()	HITE
15-0	in 72 h)iete	15. Decedent's Ed (Specify only highest grad	de completed)	(Give kin	it's Usual Occup id of work done i NOT use retired	during most of wor	kıng	16b. Ki	nd of Business/li	ndustry
2121	od within rgiene. er than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	TRU	CKDE	SIVER		TR	UCKII	NG
and	2 should be filed within and Mental Hygiene. ie markad other than aumatic avant, It.e Ms	Be	17. Father's Name (First, Middle, Last)	CGII KEN	MOTI		18. Mother's Nan	ne (First, Middle	, Maiden	Sumame)	
Maryland	should and Me e mark	J.	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing A	Address (Street	and Number or Ru	ral Route Numb	er, City o	r Town, State, Zi	ip Code)
	of Health a		DAVIDW KENTON	JY. 500	Place of Disposition	ASHIN on Warrand	GTONF	Date ,	2112	SEVIL	EDE 1993
altimore,	Pages 1 nent of 1- nt: if its iry or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cremate	ony or other place	*) -TEDU 11	14 06	1200.00	cation - City or T	Wh, State
altir	permit. Page Department of Important: if any injury or once.		21. Signal is of Funeral Service Licen		22. N	lame and Addres	ss of Facility	RALT	lomi	E	10.0
8	207 2 9		23a. Part1. Enter the disease, or comp	lications that caused the deal	311	S MAI		Deeals	BUK	5.MO2	21632 Approximate
I	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line.		Ah	4. + h.o.	· a			Interval Between Onset and Death
彩	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	- ALVVI	gilivi	100			
		ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):	Card	iomyc	path	4		
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9289	certificate be iding physicie ise as the bu	Medic	IF FEMALE:	0							
O. Box	death e atter	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	aldeath 3⊟Ed	ctopic pregnancy ther (specify)				23d. Date of deliv Month	very Day Year
s, P.O	requires thet the de een signed by the hould be detached	by Ph	Part II. Dther significant conditions of	ontributing to death but not res	sulting in the unde	artying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ords	w require been sig should b							10	Yes 2	□No 3□Pro	bably 4 Unknown
Rec	e law has b je 2 sl	Completed							psy omed?	prior to co	opsy findings available ompletion of cause of
ital	vician: Th certificate rector, pag	Be Co	25. Was case referred to medical examiner?				26. Place of Dea	1 ☐ Yes th (Check only	one)	1 ☐ Yes	2 No
of V	Physician: r this certificant ral director, in	မ	1 ☐ Yes 2 No	1		3□ DOA Oth	4 Nursing n			6 ☐Other (Speci	ufy)
lon	ding After fune	ation	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 □ No	28d. Describe	now injur	y occurred	
Division of Vital Records,	or Attendi efter death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci		t, factory, office		28f. Location (City or To	Street an wn, State	d Number or Rui)	ral Route Number,
	To the Hospital or Attenwithin 24 hours efter deatl To the Funeral Director: completely filled in by the	ledicai C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my kni iner: On the basis of examina and manner stated.	owledge, death or ation and/or inves	ocurred at the tir stigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s)	and manner as	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	10	10	729c. Licens	e number			te signed (Month)	
			11/	(KX	The		05311	0	00	tober	31,2006
			30. Name and address of person who	LDS.MD 219	S.WASH	HINGTO	NST. FI	ASTON.	MD	21601	
	Sta Regist		31. Date filed (Month, Day, Year)	2. Registrar's Sig	éture 340						

	Physici		1. Decedent's Name (First, Middle, Last James Bradford					2. Date of Deat Month NOVEMBE	Day	Year 2006	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of De		4c. County		0 (10 1
۱			SINAI HOSPITA	l of bal	TIMORE	BAL	TIMOK				
	Funeral		5. Social Security Number 6. S		yrs. last birthday,	If Under 1 Year Months Days		rs. 8. Date of Birth in. Month, Day, 7/1/193	Year)	9. Birthp	place (State or Fore
	Director		412-46-5766 Usuel Residence of Decedent	XM 2□ F 75	Yrs.			7/1/193	31	Geor	rgia
	/iand		10a. State 10b. County	100	c. City, Town or L	ocation				1	10d. Inside City Limi
	Man 9-f•h	ţċ	MD Howard	: 22	Columb	ia					1 X Yes 2 ☐ N
	or 286	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cour	ntry?
	23a		10001 Windstre	am Dr. #404		2104	4		U.S.	Α.	
	ar deg	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of I	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ce - Americ	can Indian, etc.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental hygiene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28e-f show eny injury or other traumatic event, the Medical Examination resulted.	y F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 🛛 Yes 2 🗌 No If Yes, Give Year or Dates: KO1	rea	1 ☐ Yes 2 🖾 No	Specify:		Specif	^{∱y:} Whi	te
21215-0036	2 hou	Completed by	15. Decedent's Ed		16a. Dece	dent's Usual Occu	pation		16b. Kind of B		
2	hin 72	ple	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of d)	working			330.7
7	er the	P C	12	7	Teach	er			Music		
פ	be file	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle, M		ne)	
₹	ould Men varke	은	Julian Neville					Lillian Ov			
Maryland	12 st h and 7 te n traum		19a. Informant's Name/Relationship (Barbara King (= :				Rural Route Number, #404 CC			21044
	1 and Health em 27 ither tr		20a. Method of Disposition						20c. Location		
Baltimore,	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5)	Tiomoval nom State		osition (Name of matory or other pla cris & Co	<i>сө)</i>		lest Ch		
≣	artme ortan injur		21. Signature of Funeral Service, Licer								., ER
ñ	permit. Departrimports imports ony inju		>Kirien Aby	W. CNSIN	hee.	Tarring- Aberdeen	Cargo F Maryl	uneral Hon and 21001	1e_3399 ^A	•	
	€.		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SEPS	15						Onset and Death
	/Medical		resulting in death)	Due to (or as a co							2 day
ı	Examiner	_	Sequentially list conditions.	. ACUTE		AL FF	IILUR	3			2 day
7	be sit	ine	Sequentially list conditions; if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	nsequence of):						
	xecut and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of):					-	
9	s be e Sician buria	<u>ea</u>		,	,						
Box 68/60,	death certificate be executed e attending physician and d for use as the burial-transit	clan/Medical		. 6.							
ŏ	h cert andin	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		7C-4i			23d. Da	ite of delive	ary
		sicia	in the past 12 months? 1 Yes 2 No	4 ☐ Pregnant at time	of death 5	□Ectopic pregnanc □ Other (specify) _	у		Mo	onth	Day Year
J.	The law requires that the de ste has been signed by the . bage 2 should be detached	Physi	9 Unknown								
Š,	res th signed lbe d	þ	Part II. Other significant conditions of	ontributing to death but no	_		ven in Part I.				he cause of death?
Records,	requi	Completed by	COlocatine	L(to V to 1	1-11100	N C		_ 1 \ Y e	s 2□No		pably 4 □Unknov
ě	elaw hasb	Jd I						24a. Was a autops perform	n 24b.	Were auto	psy findings availat mpletion of cause o
<u>_</u>	n: Th licate r. pag							1 ☐ Yes 2	No No	1 Yes	2 No
Vita	Physician: r this certific ral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	аПср _{(О-4}	ot ot	300	Death (Check only on			
o	Phy er this eral d	۳. ا	27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	of 28c, Inju	rv at	g Home 5 Reside			y)
0	ath. r: Afte	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury	M 1 □	rk?]Yes 2 ∐No				
Division of	r Atte er deg recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S)	At home, farm, st	reet, factory, office		28f. Location (St. City or Town	reet and Numi	ber or Rura	I Route Number,
ā	itei o rs aft rei Di	Š		, , , , , , , , , , , , , , , , , , ,				0.07 61 7 611	., οιαιο/		
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	Check only 2 Medical Exer	ysician: To the best of my niner: On the basis of exa	knowledge, dear mination and/or in	th occurred at the ti	me, date and pla	ace, and due to the ca	ause(s) and m	anner as s	tated.
۰	within 2 To the	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens					
			Daniel July	on . M	BBS	R E		_	9d. Date signe		Day, Year)
	10		30. Name and address of person who						OVCIAD.	Chj	11,2000
	6		SUMIT TALWAR	SINAL H			LTIMOR	6			
	Sta	ate	31. Date filed (Month, Day, Year)	32. Rigistrar's S		7					
	Regist	rar	NOV 1 6 2	006	N. 1	naski)					

			1 - For State Registrar	State of Marylan			of Health ar of Death	nd Mer		ene 3. No. 2 0	06	36329
ì	Physici /Medio Examin	cal	1. Decedent's Name (First, Middle, La MARY 4a. Facility Name (If not Institution, give)	J. KE	YDA	4b. City, To	wn, or Location of sbury		Date of Death Month 16 2	Day 4c. Coun	Year 2006 ty of Death	3. Time of Death 1345 M
	Funeral Director		216-18-4140		last birthday) 2 Yrs.	If Under 1 Y	ear If Under 24 ays Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day, 12 8	(ear) 1923	9. Birthp Coun VA	lace (State or Foreign try)
aryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "naturel, or Items 23s or 28s-f show emy fujury or other traumatic event, the Medical Examinal must be notified at ODGs.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD Worcest 10b. County Worcest 10c. Street and Number 901 Edgewater Av 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest grave) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last, Stephen Parusze 19a. Informant's Name/Relationship (Carolyn Keydash 20a. Method of Disposition 1 Burial 2 Cremation 3 Carolyn Science (Special Companion 5 Conter (Special Contents) 21. Signature of Funeral Service Licents	er Occ e. 12. Was Decedent Ever in U Armed Forces? 1	16a. Decer (Give life.) Sales 19b. Mailin 65 Place of Disposemetery, creived ale Ce	10f. Zip Co 2184 Was Deceden If Yes, specify 1 Yes 28 dent's Usual Co kind of work of DO NOT user 3.—Manag ang Address (S 52 Sou bestion (Name malory or othe matery 2. Name and A	2 of Hispanic Original Cuban, Mexican, Mexican, Mexican, Mos Specify: Cocupation for during most of etired 18. Mother: Bla: Items and Number 18. Treet and Number 18. Tree	of working Is Name (Fi nche or Rural Rd Rd Date 0-31- The	irst, Middle, M Szablov Dute Number, Berlin, 2006 Wh Burbage	USA 14. Ra Bli Spec. 8b. Kind of I Reta aiden Surna USKi City or Town MD 2 Dc. Location naleyv E Fune	ace - Americack, White, white wifty: Whi Business/Inc. 1111 1111 1111 1111 1111 1111 1111	an Indian, etc. te sustry Code) wn, State MD
. Box 68/60,	w requires that the death certificate be executed We described by the ettending physicien and should be detached for use as the burial-transit	d by Physician/Medical Examiner	23a. Par1. Enter the disease, or com shock, or heart hallure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknowh	a. Due to (or as a consequence of pregnant at time of consequence of the consequence of t	inuence of): NO Muluence of): NO Muluence of): A Y Inuence of): ancy I death 3 [I death 5 [ART	F LI DF CI RRY	UNG BRV	IX BAS	23d. D	ntribute to th	Approximate Interval Between Onset and Death Fy Day Year e cause of death? ably 4 Unknown
Division of Vital Recor	To the Hospital or Attending Physician: The law requivabilin 24 hours after death. To the Funeral Director: After this certificate hes been completely filled in by the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director.	Medical Certification: To Be Completed	one) /2 Medical Exa	28a. Date of Injury (Month, Day Year)	(y) owiedge, deat	f 28c. M reet, factory, or h occurred at the vestigation, in	Other: 4 Nurs Injury at Work? 1 Yes 2 Notice the time, date and my opinion, death	28d.	24a. Was an autopsy perform 1 Yes 2 heck only one 5 Resider Describe how Location (Streetly or Town, due to the caut the time, dat	24b 24b 24b 2vinjury occur 24b 24c 25c 26c 27c 27c 27c 27c 27c 27c 27	Were autop prior to con death? 1 ☐ Yes ther (Specify prior or Rural prior or Rural prior or Rural prior or Rural prior or name as st., and due to	osy findings available in pletion of cause of 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
В	A 6	ate	30. Name and address of person who SHUMM WAR IS 31. Date filed (Month, Day, Year)	26 2-66 APJ	n 23a) (Type,	D &	cense number	p+		10/	28/6 28/6	06

06-08243 Kamari Kimble

Please Type or Print in Black Indelible ink State of Maryland / Department of Health and Mental Hygiene

2006 36330

		1- For State Registrar		Certi	ficate of	Death		R	eg No	00 3033
Physicia ledical Examir		1. Decedent's Name (First, Middle K Mari	M. Kimbl	.e				2 Date of Dea Month October 3	Day Year	3. Time of Death 1547 hrs
		4a. Facility Name (if not institution Southern Maryland Ho			4	b. City, Town, Clinton	or Location of D	eath	4c. County of D Prince Geo	
Funeral Director		5. Social Security Number 212–77–3250	6. Sex 7. Age	(In yrs. last	birthday) Yrs.	If Under 1 Ye		4Hrs 8 Date of Bi Min. 08/20/	rth(MM/DD/YYYY) 9	Birthplace (State or or oreign Country) Maryland
ý		Usual Residence of Decedent 10a State 10b, County		10a City Ta	own or Location		<u> </u>	00/20/		
nd show any ce.	١	,	e George's		Heights					10d Inside City Limits 1 XYes 2 No
e Maryland or 28a-f show fied at once.	Director	10e. Street and Number 5606 Woodland Dri				10f. Zip Code	V ₁ 5		0g. Citizen of What o	Country?
ms 23a (11. Marital Status	12. Was Decedent	ever in U.S.		Decedent of h	lispanic Origin?	(Specify Yes or No	- 14 Race - A	merican Indian, Black,
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene Tiem 27 is marked other than "natural", or items 23a or 28a-f she ir transmatic event, the Medical Examiner must be notified at once	y Funeral	1 X Never Married 2 Ma 3 Widowed 4 Divo	illed	OX No		Yes 2 X N		uerto Rican, etc.)	White, et	Black
hours a "natura Examir	ted by	15. Decedent's Education (Spec Elementary/Secondary (0-12)	or Dates: Ify only highest grade com College (1-4 or 5				ation (Give kind fe DO NOT use		16b. Kind of Busine	ess/Industry
5-0036 led within 72 hours a tygiene other than "natura	Completed	Ō			NC)NE			N	ONE
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Keith Edward	_{Last)} Williams				18.Mother's N	lame (First, Middle, stina Fran	,	e
MD 2121 nd 2 should be fi lith and Mental m 27 is markee aumatic event,	٩	19a. Informant's Name/Relationsh Christina F. Kimbl							mber, City or Town, S	
re, M 1 and 2 f Health If item 2 er traur	ŀ	20a Method of Disposition	3 Removal from Sta		ce of Disposit	ion (Name of c er place)	emetery,	Drest Height Date	s, Maryland 20c. Location - Cit	20/45 y or Town, State
Baltimore, MD permit Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumant		4 Donation 5 Other Spe 21. Signoure of Funeral Service I	ecify:	Ceda	r Hill C	enetery		/04/2006	Suitland,	
Ba perm Depa Impo		And P. Kal	M. h.			ame and Addre		George P. I 1 Oxon Hill	Yalas Funera Maryland	1. Home PA 20745
Physician /Medical		23a Part I. Enter the disease, or of failure. List only one cause of	on each line			-		ac or respiratory ari	est, shock, or heart	Approximate Interval Between Onset and Death
-xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Sudden une Due to (or as a conse		ed death	in inia	ncy			Dodu'i
, p	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a conse	quence of);						
ed •	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):						-
e execute cian and rial - trar		X UNPENDED	AMENDED#1,7,	23a.27.	.28a-f.	perME. øk	 862. 12/1	 6/06 TT		
68760, certificate be ex nding physician se as the burial	2	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of pregnar	псу		Ectopic pre		23d Date of deli	ivery Day Y ear
X th	ysicia	past 12 months? 1 Yes 2 No 9 Unkr	4 Pregnant at t			er (Specify)				,
res that the signed by the be detached	by Phys	Part II. Other significant condition	ons contributing to death	but not resu	ıltıng in the ur	nderlying cause	given in Part I.			e to the cause of death?
ords, Foreguires speen signs should be								24a Was	an 24b. Were	Probably 4 Unknown e autopsy findings available
Vital Records, system : The law require this certificate has been sit director, page 2 should b	Completed		· · · · · · · · · · · · · · · · · · ·			<u> </u>		autor perfo 1 ✓ Yes	rmed? deat	
tal Rectian: The	Bec	25. Was case referred to medical examiner?				26.Pla	ce of Death (Ch	eck only one)		
Physic Physic or this	유	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatier		R/Outpatient	<u> </u>		ursing Home 5	Residence 6 🗸 0	ther: Scene
nn of nding Pt th :: After	<u>ë</u>	1 Natural 5 Pendi	28a. Date of Injur (Month, Day,Ye	ar)	Bb. Time of Inj	1	jury at Work? Yes 2 👿 No		how injury occurred	
Division tal or Attendi rs after death al Director: A	icat	2 Accident Invest	tigation 10/31/20		nd 3:00 e. farm. street	pm		unknown	Street and Number of	Rural Route Number City
Div pital or ours aft reral Di	Certification:	4 Homicide determ	minod be		er's hom			or Town, s Ft. Wash	state) 3015 Mar ington, MD	Rural Route Number, City quis Drive
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying Phone) 2 ✓ Medical Exam	ysician: To the best of my niner:On the basis of exam	knowledge, ination and/	death occurre or investigation	ed at the time, on, in my opinio	date and place, on, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due t	started. o the cause(s)
To To	ĕ	29b. Signature and title of certifier	and manner stated	_		29c. Licer	nse number		29d Date signed	(Month, Day, Year)
		Jashe 1	Seufu	C		0.0	.M.E.		November 1,	
		30 Name and address of person tasha Greenberg MD.				Penn Street	, Baltimore,	MD 21201	•	
Sta Regist	ate rar	31. Date filed (Month; Pay, Year)	5 2006 32. Registrar		is do	alle)				

			1 - For State Registrar	State of Marylar		artment of H tificate of L		d Mental Hy	giene Reg. N2 0 0 6	36331
	Physicia		1. Decedent's Name (First, Middle, Last) LUDWIG M. LON					2. Date of De	ath	3. Time of Death 6:10am м
l	/Medic Examin		4a. Facility Name (If not institution, give s Ravenwood Luthera			4b. City, Town, or		eath	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex		"	Hagersto If Under 1 Year Months Days	If Under 24 h	8. Date of Bi (Month, Di Sept. 23		rthplace (State or Foreign Jountry) Mary land
	inyland show d at		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	or 28a-f	Directo	Maryland Washir 10e. Street and Number	-	<u>H</u>	agerstowr 10f. Zip Code	1		10g. Citizen of What C	1XX es 2 □ No
ဖ	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23s or 28s-f show or other treumstic event, it is Marical Examiner must be notified at	Funeral Director	1158 Luther Driv 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 17 Yes 2 1 No 1	942- '	Was Decedent of Hi I Yes, specify Cuba		(Specify Yes or Neerto Rican, etc.)		
21215-0036	72 hours a "naturel", o	by	3 ₩ Widowed 4 □ Divorced 15. Decedent's Edu (Specify only highest grade	If Yes, Give Year or Dates: 1	945 16a. Decec (Give	1 ☐ Yes 2 X No lent's Usual Occupa kind of work done of	uring most of v	working	Specify:	White S/Industry
d 2121	filed within Hygiene. ther than int, tre Ma	Completed	Elementary/Secondary (0·12) 10 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		rrectiona	ol Offi		State of I	Maryland
ırylanı	should be ind Mental Ind Mental Indianaked o	To Be	George B. McClel		19b. Mailir	o Address /Street a	Alic	e Shehar		Zin Code)
re, Ma	s 1 and 2 s Health ar Item 27 ls other treu		Ludwig M. Long, II		#6 Mc		ail Rd		, Montana 20c. Location - City o	59716
Baltimore, Maryland	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other <u>once.</u>		1 Burial 2 Cremation 3 F 4 Donation 9 Nother (Specify) 21. Sign rure of Tuneral Service Ce	amoval moin State	eenlawn	Mem. Par	k Nov	Home, P.A	Williamspor	rt, Maryland 21795
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the dea	ith. Do not ent	er the mode of dying				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):		Vanc	en a.	um	n
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.O. Box 68	ne death certif the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
ecords, P.	ires that signed b	by	Part II. Other significant conditions con			nderlying cause give	in in Part I.		tobacco use contribute Yes 2 \(\text{No} \) 3 \(\text{F}	to the cause of death? Probably 4 (4) (4) (4) (4) (4) (4) (4) (4) (4) (
α	e law has b	ompleted	,					24a. Was auto perfi 1 \(\triangle Yes	psy prior to death?	utopsy findings available completion of cause of
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of	ding After fune	\vdash	27. Manner of Death 1 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injury Work	at at	-	idence 6 Other (Sp. how injury occurred	ecify)
Division	tel or Attenders after deatle Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str ify)	eet, factory, office			Street and Number or F wn, State)	lural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	n occurred at the tim vestigation, in my op	e, date and pla inion, death o	ace, and due to the courred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 24 To the Complete	Me	29b. Signature and title of certifier	-0		29c. License			29d. Date signed (Mor	
ولا	H-12+1		30. Name and address of person who co		em 23a) (Type,	Print)	MAG	ERSTOR	va no :	21740
	Sta Registr		31. Date filed (Month, Day, Year) OCT 3 1 20	32 Begistrar's Sign	naturo					

			1 - For State Registrer	State of	Marylan		artmer rtificat			and M		Reg. No.	006	36332
	Physicia		Decedent's Name (First, Middle, Last) Richard		Louns	burv					2. Date of Dea Month Octobe		2006	3. Time of Death 7:00 p M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o	of Death			nty of Death	,,,,,,,
			616 Richmond S						rryvi		,		Cec	
	Funeral Director		219-34-1793	7. M 2□F	Age (In yrs.	/ast birthday) Yrs.	If Unde Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day Aug. 18	,1938	Cou	place (State or Foreign ntry) t Virginia
	iryland ihow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation						1	0d. Inside City Limits
	he Ma	Director	Maryland Ceci 10e. Street and Number	1			404 7		ryvil	.le		10= Citi	of What Cour	1 X Yes 2 □ No
	Sa or	וסו	616 Richmond Str	eet			10f. Zip	Code	21	903		rog. Citizerr	U.S.	•
	death	Funeral	11. Marital Status	12. Was Deced		J.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	14. F	Race - Americ	
2-0030	be filed within 72 hours after death with the Maryland ald hyglane. An Hyglane of other than "natural", or iteme 23s or 28s-f show event, I've Medical Examinar must be indiffed at	ρλ	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Date	⊠ No		1 ☐ Yes		Specify:		, , , , , ,			White
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yland	id be filed ental Hygic ked other ic event, II	To Be (17. Father's Name (First, Middle, Last) Elihu Loren	zo Loun	sbury						e (First, Middle, Lavada			
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	of Heelth of Heelth I item 27 r other tr		20a. Method of Disposition	(51500	20b. F	Place of Dispo	osition (Na	me of	1		Date		on - City or To	
Ē	Pagent nt: i		1 ☐ Burial 2 🖾 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		are	A. Ferr			1	11/0	2/06	West C	nester,	Pennsylvania
Baltimore,	permit. Departminporta		21. Signature of Funeral Service Licens	alle v	ZDV.	<r l<="" td=""><td>2.Namea ee A. erryv</td><td>Pat</td><td>terso</td><td>n &</td><td>Son Fun</td><td>eral H</td><td></td><td>P.A.</td></r>	2.Namea ee A. erryv	Pat	terso	n &	Son Fun	eral H		P.A.
į.	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that cause on each	ch line.	th. Do not en	ter the mo	de of dying	g, such as	cardiac	or respiratory ar			Approximate Interval Between Onset and Death
	/Medical Examiner				as a consec	quence of):	,				0			
	uted 1	mlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	quence of):								
/60,	ate be executed hysician and the burial-transit	Ical Examin	that initiated events resulting in death) Last	Due to (or	as a consec	quence of);								1
Š	rtificating phy		IF FEMALE:	-				-						
O. BOX	ne death certificate the attending phys thed for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		h 2 ⊡Feta ntattime of o	at death 3[⊒Ectopic p ⊒ Other (s _i						Date of delive Month	ery Day Year
7	w requires that the de been signed by the a should be detached	ρ	Part II. Other significant conditions co.	ntributing to dea	th but not res	sulting in the u	inderlying o	ause give	n in Part I					he cause of death?
Records,	v requi	eted		·							1 🗆)			pably 4 Unknown
	The lay ste has page 2	Completed									autop	rmed?	pnor to co death? 1 \(\text{Yes}	mpletion of cause of
VIta	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		250.0		Othe			h (Check only o	-		
n of	ding Phy h. After this funeral di	on: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month)		28b. Time of Injury	of :	28c. Injury Work	at c?		ome 5 🖾 Resid 28d. Describe h			y)
Division	Atten deat octor:	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place o	f Injury - At h j, etc. <i>(Speci</i>	nome, farm, st	M reet, factor		Yes 2 🗆	No	28f. Location (S City or Tox		ımber or Rum	al Route Number,
_	Hospita 4 hours Funerei ely fillec	Medical Ce	29a. Certifier 1⊠ Certifying Phy (Check only 2 Medical Exami	ner: On the bas	is of examina	owledge, deat ation and/or in	th occurred	at the tim	ne, date an	nd place, ath occur	and due to the	cause(s) and date and place	manner as s	tated. o the cause(s)
	To the Hos within 24 h To the Fun completely	Med	one) 29b. Signature and title of certifier	and manne	r stated.		29	c. License	number			29d. Date sig	ned (Month,	Day, Year)
	⊢≯⊢ŏ		5/	10				HAA	530	7.6			1116	
			30. Name and address of person who o	mpleted cause	of death (Ite	m 23a) (Type,	CD-1-43				/			
	Sta	to	31. Date filed (Month, Day, Year)	01 Z. Re	gistrar's Sign	14 Jaun	K.d,	Hoi	Dep	أرعت	mo	CAR	y	
	Regist		NOV 0 2 2001	Bear	10 10	K GOD	Wes							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygien 2000 6

		•	Tor State Registrar	State of Ma	iryianu / L	Certificate o	f Death	nentai Hygier Reg. i		36333
	Physici		1. Decedent's Name (First, Middle, Last) John Gordon L					2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town	, or Location of Death		4c. County of Dea	0012
		Ш	5. Social Security Number 6. Sex	TY NULL	(In yrs. Tast bin	thday) If Under 1 Yea	ar If Under 24 Hrs.	R Date of Righ	NOSN	rthplace (State or Foreign
	Funeral Director		216-09-3362	M 2□F		Yrs. Months Day		8. Date of Birth (Month, Day, Yea October 2	5 1919	Maryland
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location				10d. Inside City Limits
	e Mar sa-f sh tillisu	ctor	Maryland Washin	gton		Hagerstown	n			X□Yes 2□No
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than "natural" or items 23a or 28a-f show re Modicel Exercities at	Funeral Director	10e. Street and Number 114 W. Wilson	Blvd.		10f. Zip Code	21740	10g. (Citizen of What C	
	r deat	ner	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was Decedent o	f Hispanic Origin? (Sp uban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
980	ours afte	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	1∭Yes 2 □ N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ☐XN			Specify: W	·
15-0	n 72 ho "natu	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a.	Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti	cupation ne during most of work	sing 16b.	Kind of Business	s/Industry
212	T 12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	dmo	Elementary/Secondary (0-12)	College (1-4or 5	+)	Store Owne			Grocerv	
nd	0 = 0	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Maid	en Sumame)	
Maryland 21215-0036	should nd Mar marke matic	ို	Charles Lewis 19a. Informant's Name/Relationship (Ty)	рө, Print)	196	. Mailing Address (Stre		Shipley Tal Route Number, Cit	y or Town, State,	Zip Code)
	nd 2 lith a 27 Is r tra		Ruth Marie Lewis	(wife)	1	14 W. Wilso Disposition (Name of	on Blvd. Ha	agerstown	Maryland	21740
nore	Pages 1 and nent of Head ant: If item arry or other		20a. Method of Disposition 1 □ Burial 22 □ Cremation 3 □ R * 4 □ Donation 5 □ Other (Specify)	emoval from State	cemeter	Disposition (Name of y, crematory or other posturg Crema	nace)			r Town, State
Baltimore,	permit. Pages Department of Important: If i any injury or o		21. Six sture of Funeral Service License	96 > '	- Janzon	_	- 1	uglas A. F		
	20 = 8 0	4	23a. Part 1. Enter the disease, or compli	cations that caused	the death. Do r	1331 East	ern Blvd.	N. Hager	stown, M	aryland 2174
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each lin	θ.	or ornor the mode of a	y 19, 00011 do 041 dido	or respiratory arrest,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence	of):				107
	Examiner % -e	ē	Sequentially list conditions,	Due to for as a	M (a) S	Disease				104
	cuted nd ransit	Examine	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· 1.	ŕ					
68760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	a consequence	of):				
687	tificate ng phys as the	Aedicai								
Box	death cer e attendir ad for use	Physician/N	in the past 12 months?	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregnar 5 □ Other (specify)			23d. Date of de Month	olivery Day Year
P.0	that the de ed by the a detached		9 ☐ Unknown Part II. Other significant conditions cor		it not resulting in	the underlying cause	given in Part I	23e Did tobacc	o use contribute t	o the cause of death?
rds,	w requires t been signe should be	ed by				, and disacrifting datases	givon in raici.	1 🗆 Yes		robably 4 Manknown
Record	e la has	Completed						24a. Was an autopsy performed:	prior to death?	utopsy findings available completion of cause of
Vital		Be C	25. Was case referred to medical examiner?				26. Place of Deat	1 ☐ Yes 21 ☐ 1 h (Check only one)	40 1 1 Yes	s 2□No
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 No	lospital: 1 🗆 Inpatier		tpatient 3_DOA		ome 5 Residence		ecify)
	Jing After fune	tion	27. Manner of Death 1 ★ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y 285. 1 'Yea <i>r)</i> I	Time of 28c. In njury W	jury at /ork? □ Yes 2 □ No	28d. Describe how in	jury occurred	
Division	l or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ıry - At home, fa :. (Specify)	rm, street, factory, offic	ee	28f. Location (Street City or Town, Str		lural Route Number,
			29a. Certifier 17 Certifying Phys	sicien: To the best of	of my knowledge	, death occurred at the	time, date and place,	and due to the cause	(s) and manner a	s stated.
	To the Hospita within 24 hours To the Funeral completely filled	Medical	one)	ner: On the basis of and manner sta	examination an ted.	d/or investigation, in m				
	with To	2	29b. Signature and title of certifier				52323	29d. [Date signed (Mon.	th, Uay, Year)
•			30, Name and address of person who co	empleted cause of de	eath (Item 23a)		1 6 7 6 5	1	7 90	21740
4	19+1		Khalid Wase	em 11	26 OF	al Cour	+ Hage	erstow.	1 MD	21740
::	Sta Registi		31. Date filed (Month Cay, Year) 20	06 32. Registra	ur's Signature V	South.	,			

		1 - Formend #5 Per FH C86	2 ^{State} 01/0 ^{May}	Yland / Depa	artment of H	lealth and Death	Mental Hyg	iene 006	36334
Physici /Medic		1. Decedent's Name (First, Middle, Last) Philip E.		Lindner			2. Date of Deat Month	Day 2000	
Examir		4a. Facility Name (If not institution, give s 331 Bedford Street		Married to Abrida to A	4b. City, Town, or Cumberl	and		4c. County of De Allegany	
Funeral Director		5. Sept Security Number 6. Sept 214-16-4955 Usual Residence of Decedent	N 00 F	(In yrs. last birthday)	Months Days	Hours Min		922 N	inthplace (State or Foreign
Maryland s-f ehow fied at	tor	MD 10b. County Allegany	1	10c. City, Town or Lo Cumb	perland				10d. Inside City Limits 1 X es 2 No
h with the 23a or 28a	al Director	10e. Street and Number 331 Bedford Street			10f. Zip Code	21502	10	0g. Citizen of What 0	Country?
72 hours after death with the Maryland 72 hours after death with the Maryland 7-naturel', or Items 23e or 28e-f ehow olds! Erb infractional be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	WWII	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - An Black, Wh Specify: Wh	ite, etc.
I within jiene.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0·12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of we	orking	Pontiac-Ca	
should be filed and Mental Hygis marked other umatic event, in	To Be C	17. Father's Name (First, Middle, Last) John H. Lindner				Teresa	ıme (First, Middle, A ı (Lehman	n) Lindner	
s 1 and 2 should f Health and Mer item 27 is mark		19a. Informant's Name/Relationship (Ty Melba Lindner	_{ов. Print)} wife	331	Bedford S	and Number or F Street	Cumbe	City or Town, State, erland	Zip Code) MD 21502
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dispondent of Commetery, cred	matory or other plac	ee)	2,450	Cumberlar	
permit. Pages Department of Important: If any injury or any injury or		21. Signatur of Funeral Service Licens	NVVV		2. Name and Addre Scarpell 108 Virg	inia Avenu	ie: Cumberla	and, MD 215	02
Pnysician /Medical	er v	23a. Part Enter the disease, or compliance, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	and an analysis of					onary Dist	Approximate Interval Between Onset and Death
death certificate be executed the attending physicien and the as the burial-transit and the art the prival transit and the art that the art the prival transit and the art that the art the art that the art that the art that the art that the art that the art that the art that the art the art that the art that the art that the art that the art the art that the art that the art that the ar	dicai Examiner	Sequentially list conditions, if any, leading to moneutiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Duerto (or as a	consequence of):					>10 you
he death certifi the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
g 2 g	d by	Part II. Other significant conditions con	itributing to death but	not resulting in the u	nderlying cause giv	en in Part I.			to the cause of death?
The ate h page	Complete						24a. Was ar autops perform 1 Yes 2	y prior to ned? death? ₽ 2 No 1 □ Ye	
Physicien: Tribis certificat	To Be	TU TES ZE NO	ospital:			er: 4 🗆 Nursing	eath (Check only one Home 5 Reside	e) ince 6 □Other (Sp	ecify)
ending eath. or: After	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Yea <i>r)</i> Injury	M 1 🗆	yat k? Yes 2 □No	28d. Describe ho	w injury occurred	
oltal or Att urs after d rei Direct		4 Homicide determined		y - At home, farm, st (Specify)			City or Town		
To the Hospital within 24 hours a To the Funeral I completely filled	edicai	(Check only one)	ner: On the basis of e and manner state	examination and/or in	n arruned at the tin evestigation, in my o	ne, date and plan pinion, death occ	e, and die to the ea surred at the time, da	ltts(t) and manner t ate and place, and di	to the cause(s)
within To th	W	29b. Signature and little of certifier	00		29c. Licenso	337/		Pd. Date signed (Mor NOV 13	
V		30. Name and address of person who co	.D.	625 H	,	ue Cumb	erland ME	21502	
Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	3000				

Please Type or Print in Black Indelible Ink

Alexander Lewis Longfellow

		Time in Diagnama	Olibio Illik
State of Man	yland / Depart	ment of Health ar	nd Mental Hygiene

		1- For State Registrar	Cert	ificate of	Death		F	Reg No 2	106 36335
Physici Medical Exami	an/ ner	Decedent's Name (First, Middle,Last) Alexander		gfellow				ath Day Year er 6, 2006	3. Time of Death 0845 hrs
and the same		Facility Name (if not institution, give street and Twilley Bridge Road			b. City, Town, o	Location of D	eath	4c. County o Wicomic	
Funeral Director		5. Social Security Number 218-06-3064 6 Sex Usual Residence of Decedent	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Day	_	Min	2/1984	9. Birthplace (State or Foreign Countr Maryland
Maryland 28a-f show any d at once,	tor	10a. State 10b. County Maryland Wicomico 10e. Street and Number		own or Location				10g Citizen of Wh	10d Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Dire	7778 Country Creek			10f Zip Code 21830			USA	at Country?
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene is marked other than "natural", or items 23a or 28a-f she aric event, the Medical Examiner must be notified at once	by Funeral	1 X Never Married 2 Married 1 Ye 3 Widowed 4 Divorced If Yes, Give	Year	If Ye	es, specify Cuba Yes 2 X No	n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	White,	white
11215-0036 Id be filed within 72 hours dental Hygiene narked other than "natun event, the Medical Exam	ompleted	11 -	grade completed) e (1-4 or 5+)		s Usual Occupa st of working life	e. DO NOT use	retired)	16b. Kind of Bus	
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be Co	17. Father's Name (First, Middle, Last) Alyne Lewis Longfellow					ame (First, Middle, on Daughe	,	
MD 21 d 2 should th and Me n 27 is ma	2	19a Informant's Name/Relationship (Type, Print) Alyne L. Longfellow/fa	ther				or Rural Route Nu , Hebron		
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic		20a. Method of Disposition 1 X Burial 2 Cremation 3 Remove 4 Donation 5 Other Specify:	· ·	ematory or othe	ion (Name of ce Memoria	ı	Date L1/11/06	i	City or Town, State
Baltir Permit Departme Importa		21. So ature of Fine South Licensee 21. So ature of Fine South Licensee 22. Part I. Enter the disease, or complications the	ESP	²² No HO 1 50	I Snow	s of Facility Funeral Hill Ro	Home Pr	ofessiona bury, MD	al Association 21804
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Narco	tic intoxica	ation					Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	as a consequence of): as a consequence of): as a consequence of):	:					
760, icate be executed physician and the burial - transit		events resulting in death) Last Due to (or a d							
∞	Physician/Medical	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 23c. If ye 1 Liver years	#23a,27,28 es, outcome of pregna	ancy 2 Feta		11/30/0		23d Date of o	delivery Day Year
P.O. Box 68 es that the death certigened by the attending of detached for use a	by Phy	Part II. Other significant conditions contributing		sulting in the ur	nderlying cause	given in Part I.			oute to the cause of death?
_ s _a s	ompleted l		-				24a. Was	an 24b. W	Probably 4 Unknown fere autopsy findings available for to completion of cause of earth?
	C	25. Was case referred to medical	<u>-</u>		26 Place	e of Death (Che	1 Yes		Yes 2 No
n of Vital I Jing Physician: After this certifi funeral director.	n: To B	1 Natural (M		R/Outpatient 28b. Time of In	jury 28c. Inju	iry at Work?		Residence 6 V	-
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should t	ertification:	2 Accident Investigation Fnd	$11/6/2006$ Place of Injury - At hor $\frac{ify}{}$	ne, farm, street	CITIT	Yes 2 No	I TOMIN T	Street and Number	r or Rural Route Number, City Ley Bridge Road
To the Hospi within 24 ho. To the Funer completely fi	Medical C	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the ba	best of my knowledge	e, death occurr			and due to the cau	se(s) and manner a	
	M	29b. Signature and title of certifier	_		29c. Licens O.C.		-	November 7	d (Month, Day, Year) 7, 2006
		30 Name and address of person who completed of Mary G. Ripple MD. Deputy Chie	cause of death (Item 2 ef Medical Exam	,	Penn Street	t, Baltimore	, M D 21201		
S Regis	tate trar	31. Date filed (Month, Day, Year) 32 NOV 1 3 2006	Registrar's Signature	k de	all a				
DHMH 17 Rev 1/2	001		/ CI-CI-CI-CI-CI-CI-CI-CI-CI-CI-CI-CI-CI-C	ORIGINAL	TA.				

					State of Mary	rland / Dep	artmer	nt of H	ealth ar		ital Hv	aiene		20220
				Registrar		Ce	rtifica	e of L	Death				006	
	F	Physicia		1. Decedent's Name (First, Middle, Last) Edwin Bergner Lehn	24+						Date of De Month	Day	006	3. Time of Death 8:15am ^M
		Medic/ Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City	Town, or	Location of		00.		ounty of Death	
		LAGIIIII	·	Harford Memorial H	ospital		Hav	re de	2 Grac	e		На	rhord	
	F	uneral		5. Social Security Number 6. Sex	7. Age (II	yrs. last birthday		r 1 Year Days	If Under 24 Hours	4 Hrs. 8. [Date of Bir	h		place (State or Foreign into) Land
	Di	rector		218-26-1265 Usuel Residence of Decedent	M 2□F 82	Yrs.	1410111110	Dayo	110410	0 9	Month, Da 9 / 16 /	1924	Mari	iland
	iand	No m		10a. State 10b. County	10	c. City, Town or L	ocation							10d. Inside City Limits
-	death with the Maryland	id other then "natural", or iteme 23s or 28s-f ehow event, the Medical Examinar must be notified at	tor	MD Harford		Havre de	Grac	e						1 Tyes 2 No
5	th the	or 28	Funeral Director	10e. Street and Number			10f. Zi	p Code				10g. Citize	n of What Cou	intry?
D.	ath w	23a	la l	312 Cooley Mill Ro	ad			21078				USA		•
1	er de	Item Darid	une		2. Was Decedent Eve Armed Forces?	r in U.S. 13.	. Was Dece If Yes, spe	dent of His orfy Cubar	spanic Origi n, Mexican,	in? (Specify Puerto Rica	Yes or No in, etc.)	- 14	Race - Amer Black, White	
15	Maryland 21215-0036 of 2 should be filed within 72 hours after the and Mental Hydiene.	r, or	by F	1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: WU	10	1 ☐ Yes	X □ No	Specify:			S	pecify: (1) h	ite
00	2 Por	ical E		15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	edent's Usu	al Occupa	tion	of wasting	<u> </u>	16b. Kind	of Business/li	
0	21. if in 9	Wed	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				uring most o	or working				
	Noied W	4	Co	47 Fabrus Name (Fire Addute Land)	4 years	Self	-Empl	oyed	40.14-15-4	- h? /pm				Building
	and to find the find	is marked other then sumatic event, the Ms	Be	17. Father's Name (First, Middle, Last)	_					s Name (Fill Emily			ımame)	
	Should Me	Tark	ဥ	John Edwin Lehnert 19a. Informant's Name/Relationship (Type		19b. Mail	ling Addres						own, State, Zi	n Code)
	Z	7 7		Ruthanna G. Lehner	1776	1							e, MD	
3	Baltimore, Sermit. Pages 1 and	Important: if Item 27 in any injury or other tre		20a. Method of Disposition		20b. Place of Disp cemetery, cre				Date			tion - City or T	
11/6/0	Page Page	ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		Rock Run	Ceme	tery	11					
16	Salt ermit.	nport ny inj		21. Signature of Funeral Service License	~	a. N	22. Name a Utche	nd Addres	s of Facility	unera	l Hon	1e. P.	A. ice, MD	
7	m 40	트플리	4	Quanc VIII	MMH 1	-1001	1303.	Wash	ringto	in, Ha	ure o	le Gro	ice. MD	21078
				23a Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the e cause on each line.	death. Do not er	nterthe mo	de of dying), such as ca	ardiac or re	spiratory a	rrest,		Approximate Interval Between Onset and Death
		sician edical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	AMH	4/1/1	19						SELDING
-		miner		APOCINE AMERICAN CONTRACT	MYD! An	onsequence or):	1-141	1:77	* /					10 7 mos
			ner	cause. Enter Undertying Cause (Disease or injury	Due to (or as a co	onsequence of):	<i>/~ / ///</i>	60776						10000
V	760,	sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	COLUMPA	ラカー・イブスレップピ	nig 1	1565	K					12 45mg
	760,	cian a		resulting in death) cast	Due to (or as a co	onsequence of):								
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27	Box 6	nding use a:	√Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of p							23	d. Date of deliv	verv
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EA	Records, P.O. Box 68 a law requires that the death certifica	been signed by the attending physician should be detached for use as the burial		Part II. Other significant conditions con	tributing to death but n	ot resulting in the	underlying	cause give	in in Part I.			,		the cause of death?
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	<u>a</u>	certificate has rector, page 2		25. Was case referred to medical							1 Yes	2 PNo	1 Yes	2 No
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3	P. G.	erald erald	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Ye		of	28c. Injury	at			how injury	Other (Spec	iry)
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	Hospital	mining to provide the formal director, page completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1	sician: To the best of n ner: On the basis of ex and manner stated	amination and/or i	ath occurred investigation	d at the tim	e, date and pinion, death	place, and occurred a	due to the	cause(s) as date and p	nd manner as lace, and due	stated. to the cause(s)
	To the	omple somple	Me	29b. Signatuse and title of certifier			29	c. License	number			29d. Date	signed (Month	. Day, Year)
) []			1 Selm MC	/			03	308	8		11/6	101	
	ih	71		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type	e, Print)					-	1 -10	
	1		1	BERNHARD BIR	NBAVA M	1 /3 2/ /	ノレから	116	CKmy	15101	4 B	元四/	2 2	10/7
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State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** VIRGINIA MOLSTER 18:18 M OCTOBER 29 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE 8. Date of Birth (Month, Day, Year) Nov . 15 19 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Months Days Hours 410-52-0530 73 Tennessee Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ral', or iteme 23a or 28a-f ehow Examiner must be notified at Montgomery Village 1 ☐ Yes 2 Mo Md. Montgomery Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 20886 8313 Frontwell Circle United States deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. be filed within 72 hours after de tal Hygiene. d other then "natural", or item: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth any liquy or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elliott Clarence Juanita Shipp 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Molster, Jr. / Husband 8313 Frontwell Circle, Montgomery Village, Md. 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crem. 10/30/06 Alexandria, Va. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home Murif H. Barba P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MALIGNANT PLEURAL EFFUSIONS Physician DAYS /Medical Due to (or as a consequence of) Examiner METASTATIC OVARIAN CANCER YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2.X No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 0990 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy rmed? 2.23 No certificate 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Dther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DDA this Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation efter death. М 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours oft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D64444 October 29, 2006 MO 10 ww 30. Name and address of perso, who completed cause of death (Item 23a) (Type, Print) Ariji Dasgupta, M.D. 9901 Medical Center Drive, Rockville, Md. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2006 3638 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 28, 2006 **Physician** 05:55A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 98 vrs 5. Social Security Number 083-10-1142 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Director Sept. 10, 1908 New York Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f ahow tra Medical Examiner mest be notified at 1 ☐ Yes 2 No Montgomery Potomac Maryland Director 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 20854 8605 Postoak Road be filed within 72 hours after death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: white þ 3 ♥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "nn any injury or other traumatic experience." Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jennie Harkavv Morris Manashaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8605 Postoak Road, Potomac, MD 20854 Gerald Meyer, Son 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Beth David Cemetery 10/30/06 Elmont, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serviye Licens Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ours affer death.

neral Director: After this certificate has been signed by the rifiled in by the funeral director, page 2 should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ₺No 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier who completed cause of death (Item 23a ype, Print) WTROSE ROAD, ROCKVILLE MD 20852 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Pedro рм Martinez 27, October 2006 8:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Rehab. & Nursing Center Burtonsville
If Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□ F Yrs. Director 219-42-1846 81 Aug. 1, 1925 Cuba Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-1 show other treumatic event, the Madical Examinar must be notified at 1 ☐Yes 2€ No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8830 Piney Branch Road, #308 20903 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: SpedWhite 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hygient importent: if Item 27 ie marked other the 12 Carpenter Window Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Juan Martinez Amalia Felicia Martinez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20903 19a. Informant's Name/Relationship (Type, Print) 8830 Piney Branch Road, #308, Silver Spring, MD Nidia M. Martinez/ Wife 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) ty Burial 2 ☐ Cremation 3 ☐ Removal from State October 31 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ۾ page 2 should be Cardiomyopathy, Hypertension 1 Tes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? 1 Yes 2 No Division of Vital 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending After 1 X Natural 5 Pending 1 Tes 2 No To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A death. investigation M 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ian Derese 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 722 32 Registrar's Signature 31. Date filed (Month, Day, Year) State aski Registrar 1 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 36340 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:00^{p м} FRANCES MARSH Oct<u>ober</u> 24, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4221 Sheridan Street Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs. | Months Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 87 Director 579-28-4187 3-1-1919 Tennessee Usual Residence of Decedent permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryiant Depertment of Heelth and Mental Hygiene. Importent: if item 27 ie marked other then "naturel", or iteme 23a or 28a-f ehow eny injury or other treumatic event, the Medical Examinant be modified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Prince George's Maryland University Park 10e. Street and Number 10g. Citizen of What Country? 4221 Sheridan Street 20782 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Library of Congress US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Matthew Alexander Mary Wily 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Bomarito - Nephew 16667 Glenwood Court, Lake Oswego, OR 97034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 BRemoval from State 11/16/2006 4 ☐ Donation 5 ☐ Other (Specify) Memory Gardens Tawas, Michigan 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CARRIOVASEL Therosol erdic Physician resutting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2□ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Conflying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HO055827 Detober 25, 2006 30. Name and address of person who come eted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) er 309 Rockylle Bky Rockville Med. 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

To the Hospital or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760.

physician and the burial-transit

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within 24 hours er To the Funeral D

the Maryland

Baltimore, Maryland 21215-0036

			State of Maryland / Den	partment of Health and Me	•	ne
		•	_ FOI	ertificate of Death	Reg.	/ UIIb 3b341
	Dhunial	7	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physicia /Medic	_	Marion Elizabeth Maris		ctober	30 2006 11:30 A M
A Section of	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Williamsport		4c. County of Death Washington
1	Funeral		Homewood Retirement Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth	O Bishplace (Class or Famine
	Director		218-34-2248 1 M 2 TF 68 Yrs.	Months Days Hours Min.	Month, Day, Y	1938 Maryland
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	Location		10d. Inside City Limits
	Mary I she	tor	Maryland Washington	airplay		1 ☐ Yes 2 X XNo
	or 284	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
	ath wi	rail	17103 Spielman Rd.	21733		USA
	ter de items	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ▼ Married 1. □ Yes 2 ▼ No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ity Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
920	ei', or		1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 XNo Specify:		Specify: White
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5	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (
/lar	should be nd Mental marked o	To B	Marion Luther Dasher	Roberta	Bowers	Jackson
Maryland 21215-0036	C/ a = 0			ling Address (Street and Number or Rural		3100
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Baltimore,	permit. Pages 1 ar Department of Hea Important: if Item eny Injury or other once.		I Dunai Zanciemation 3 Enemovaliion State			Smithsburg, Maryland
altir	permit. P Departme Importan eny Injur			3strone Afrene Faity Home		21795
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.O. Box 68760	that the death certificate by ed by the attending physic detached for use as the by	Physician/Medical		B Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
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Ť Vi	S &	To Be	examiner? 1 Yes Hospital: 1 Inpatient 2 ER/Outpat	Other • 4		ce 6 Other (Specify)
			27. Manner of Death 1 ✓ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	/ Work?	Bd. Describe how	injury occurred
Division	or Attending after death. Director: After in by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be determined of th	M 1 Yes 2 No	Bf. Location (Stree	et and Number or Rural Route Number,
Ω	a after	Certification:	4 Homicide determined building, etc. (Specify)	,	City or Town, S	State)
	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in by the	Medicai (29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	ath occurred at the time, date and place, as investigation, in my opinion, death occurred	nd due to the caus d at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of comparison	29c. License number		Date signed (Month, Day, Year)
•			- Com	0680	0	10/06/51,000b
ف	H-2		30 April address of Serson who completed cause of deaffi)(Item 23a) (Typ	Unic Dep. /Le	comba	u MD2/742
18	St	ate	31. Date filed (Month, 167, Year) 32. Registrar's Signature		10	
100	Regist	rar	OCT 3 1 2006 Re. A.	Specker		

			1 - For State Registrar	State of Maryla		artment of H		nd Mental H	giene Reg. No.		36342
	Physici /Medio		Decedent's Name (First, Middle, La Rosa Lee MILLS	st)				2. Date of D	eath Day	26 700x	3. Time of Death
	Examin		4a. Facility Name (If not institution, giv	e street and number)	nai Ho	4b. City, Town, or	Location of	Death	4c.	County of Death	noten
	Funeral Director		Social Security Number 6. 8	ex 7. Age (In yi	rs. last birthday, Yrs.	Months Days	If Under 2		av. Year)	Cou	nplace (State or Foreign untry) t Virginia
			Usual Residence of Decedent 10a. State 10b. County		City, Town or L	ocation		11011		25 Web	10d. Inside City Limits
	Ba-f sho	Director	Maryland Washin	gton	Hagers	stown					1 ☐ Yes 2 🏹 No
	3a or 2	i Dire	10e. Street and Number 9855 Crossfield	Road		10f. Zip Code 2174(1		10g. Citi	izen of What Cor	untry?
960	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show deat Examirer must be nutified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13.			in? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race - Amer Black, White Specify: Wh	e, etc.
Maryland 21215-0036	C = 3	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired	during most (f)			ind of Business/I	
1d 21	filed with Hygiene. other ther	Be Co	Unknown 17. Father's Name (First, Middle, Last	Unknown	Sewin	ng Machine		ator s Name <i>(First, Middi</i>		othing Sumame)	Mfg.
rylar	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	To E	Earl Karns	7				a Lynch			
	1 and 2 st Health and tem 27 is r		19a. Informant's Name/Relationship (Jack Mills - Son	** * *				or Rural Route Num d, Hagersi			E1340
Baltimore,	Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	cemetery, cre	osition (Name of amatory or other plac	ce)	Date		ocation - City or 1	
altim	그든본글		4 □ Donation 5 □ Other (Special21. Signature of Funeral Service Lice	, OC		Mem. Par 2. Name and Addres		0/30/06 Minnich			Maryland
8	Derm Impo		200	M/W/us				lvd. Hage	rstow		land 21740
10	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	ovascu	Lay A	CCLC	2 1	arrest,		Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons c. Due to (or as a cons		laseupay	d/S	ids e			50
O. Box 6	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 50 No 9 ☐ Unknown	23c. If yes, outcome of preductions of the second of the	etal death 3	□Ectopic pregnancy	,			23d. Date of delive Month	very Day Year
rds, P.	quires that n signed b uld be deta	by	Part II. Other significant conditions	contributing to death but not i	resulting in the	underlying cause give	en in Part I.		tobacco t		the cause of death?
Vital Records,	The law requirate has been spage 2 should	Completed						per	opsy formed?	prior to c death?	topsy findings available completion of cause of
/ital	Physiclan: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Literaitel				1 ☐ Yes of Death (Check only	one)		
of	ding Phys h. After this funeral dii	ation: To	1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)		of 28c. Injun Worl	y at	28d. Describe			ify)
Division	Dir	Certification:	3 🗍 Suicide 6 🗍 Could not be determined		t home, farm, s	treet, factory, office			(Street an own, State		ral Route Number,
	To the Hospital or Attentivitin 24 hours after deati To the Funeral Director: completely filled in by the	edical C	29a. Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my liminer: On the basis of exam and manner stated.	knowledge, dea ination and/or i	th occurred at the tin	ne, date and pinion, death	place, and due to the cocurred at the time	e cause(s) e, date and	and manner as d place, and due	stated. to the cause(s)
	To the within 2	ž	29b. Signature and title of certifier			29c. Licens	e number	7		te signed (Month	
`	20		30. Name and address of person who	completed cause of death (I	tem 23a) (Type		C) [-27-	0
	4		Khalid Waseem	1126 Opa1	Court,	Hagerstow	n, Mai	ryland 217	40		
	Sta Regist		31. Date filed (Month, Day, Year) GCT 3 0 20	32 Registrar's Signature	. 4	whit					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** November 5. 2006 Jeffrey James Marshall /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 45892 South Poteat Court California St. Mary's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 ☐ F Yrs. 25, 1957 49 Director 220-62-8044 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be 23a 45892 South Poteat Court 20619 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Black Specify: þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the 12 <u>Insulation Installer</u> Construction and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shannon Wesley Marshall Clarissa Ernestine Greenfield ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trau Sylvia Elizabeth Marshall/Wife 45892 South Poteat Court, California, MD 20619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Peter's Church C. 11-11-2006 Waldorf, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service License M01206 Kyle S. Simons 22955 Hollywood Road, Leonardtown, MD 20650-0279 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastalic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ulmonan if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autops, performed; 2 No 1☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. Director: / death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47066 H 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani D. Shah, M.D., 22650 Cedar Lane Court, Leonardtown, Maryland 20650

State

Registrar

31. Date filed (Month, Day, Year)

8 0 VON

2006

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month I. Decedent's Name (First, Middle, Last) Year Physician 1:50 P M October Barbara Ann Miller 25, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapu...

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Jan. 15, Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F 177-28-7409 72 Yrs. 1934 Pennsylvania **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Wedical Examiner must be notified at Maryland Anne Arundel Annapolis 1 ☐ Yes 2000No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 543 Pinedale Drive 21401 U.S.A. deeth Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 25No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns any injury or other treumatic event, the Media 2008. Elementary/Secondary (0-12) College (1-4or 5+) Administrator Education 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Dorothy Allahand Spencer Leroy Bunting 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Miller/husband 543 Pinedale Drive Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBunal 2 ☐ Cremation 3 ☐ Removal from State Whitemarsh Mem. Park 10/31/2006 Ambler, Pennsylvania * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Tuneral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** elater /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 100 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Noknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 \ No 200 No 1 Tyes 1 Yes Division of Vital To the Hospitel or Attanding Physicien: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 1 Yes 200 No 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation efter death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours 6 To the Funerel L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3306 Mourtis Harris 30. Name and address of person who complete . Registrar's Signature 31. Date filed (Month. State 0 2006 Registrar

			1 - For State Registrar	State of Marylan	d / Depa <i>Cer</i>	irtment d <i>tificate</i>	of Health and of Death	Mental Hygi	iene2006 og. No.	36345
	Physici /Medio		1. Decedent's Name <i>(First, Middle, Last)</i> Loretta Jo	yce Marine				2. Date of Death	ο ^ρ 7 ^y , 2006	3. Time of Death 6 0855 M
	Examir		4a. Fecility Name (If not institution, give st 3799 Bradley Ro			**	vn, or Location of Dea ralsburg	th	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I			ear If Under 24 Hrs ays Hours Min		9. Bi 1943 Ma	rthplace (State or Foreign country) ryland
	Maryland f ehow	tor	Usuel Residence of Decedent 10a. State 10b. County FL Highlan		y, Town or Lo Lak	cation te Pla	cid			10d. Inside City Limits 1 ☐ Yes 2√☐ No
	with the 3a or 28e-	i Direct	10e. Street and Number 116 Autumn Terr			10f. Zip Co	de 3852		Og. Citizen of What C	•
336	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heatih and Mertal Hygiene. Department of Heatih and Mertal Hygiene. Department of Heatih and Mertal Hygiene. The Maryland Stating of 186-1 ehow any injury or other traumatic event, the Medical Examinar must be motified at Once.	by Funeral Director		2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If	Vas Deceden	of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
Maryland 21215-0036	I within 72 hor iene. r than "nature the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life. L		ccupation one during most of wo stired)	orking	Own Home	
/land 2	wild be filed Mental Hyg Irked other	To Be C	17. Father's Name (First, Middle, Last) Harry Cohey, Sr					me <i>(Fir</i> st, <i>Middl</i> e, <i>M</i> et Loret	Maiden Sumame) tta Pitt	inger
, Mar	and 2 sho Ballh and n 27 is m		19a. Informant's Name/Relationship (Type Don W. Marine/S	pouse	116 At	utumn [reet and Number or R Cerrace, La			
altimore,	Pages 1 ment of Hi ant: if ites ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	milovai iroili State		e Crem.	Ctr. 11/	′08/06 Ca	ambridge,	Maryland
Balt	permit. Depart import any inj pnce.		21. Signature of Funeral Service Licenses	M. Coale	21	O N. P	ddress of Facility ra ain St., I	ederalsbu	irg, MD 21	, P.A. 632
,	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	216	er the mode o	dying, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
	Examiner	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of the consequence of t						
20,	ficate be executed physicien and s the burial-transit	i Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.	Due to (or as a consequ		_				
Ψ	ertificate t ling physic e as the b	Medicai	d.							
P.O. Box	the death certifi y the ettending iched for use as	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 9 Unknown	ic. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregr Other (speci			23d. Date of de Month	elivery Day Year
	The law requires thet the de ste has been signed by the opage 2 should be detached	led by PI	Part II. Other significant conditions cont							to the cause of death?
al Reco	: The law rocete has be page 2 sh.	Comple						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of s 2 No
Division of Vital Records,	To the Hospital or Attending Physicien: The law within 24 hours after death, within 24 hours after death. To the Funeret Director: Atten this certificate has completely filled in by the funeral director, page 2.	tion; To Be	25. Was case referred to medical examiner? 1 Yes No Ho 27. Manner of Death 1 Statural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ I 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury		Othor	ath Check only one Home 5 Resider 28d. Describe hor	nce 650 PAUS	hters Residence
Divisi	ei or Atten s after deal of Director of in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, of		28f. Location (Str City or Town,	eet and Number or F , State)	tural Route Number,
	ne Hospit 24 hour ne Funer letely fille	Medicai (29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my know er: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at t	ne time, date and plac my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To the within To the company	W	29b. Signature and title of certifier	14	CI		cossas		od. Date signed (Mon	
			30. Name and address of person who com	npleted cause of death (Item	23a) (Type, I	Print)				
	Sta Registr		31. Date filed (Month, Day, Year) 2006	32 Aegistrar's Signat	ture	3460				31655

			1 - For Amend #5 Per	Filat8865MP/XI87	67 Dana Cer	artment of tificate of	Health and Death		giene ,	2006	36	5346
	Physici	an	1. Decedent's Name (First, Middle, La: Claire	Elizabeth M	leredi	th		2. Date of De Month Nov •	ath Day	2006		of Death
	/Medio		4a. Facility Name (If not institution, give				or Location of Dea			ounty of Death	0.1	U I
	Exami	ier	25615 Lot 10 I				alsburg			arolin	_	
	Funeral Director		215-18-4584 6. S			If Under 1 Year Months Days	r If Under 24 Hrs	(Month, Da	th v. Year)		place (State	or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	Od. Inside	City Limits
	e Maryl	ctor	MD Caroli	ne	Fe	ederals	burg					s 2⊡xNo
	3a or 20	1 Dire	10e. Street and Number 25615 Lot 10 Is	scher Road		10f. Zip Code 216	532			n of What Cour ed Sta	•	
220	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Deperment: If teem 27 is marked other then "naturel", or iteme 23e or 28e-f ehow any injury or other traumatic event, the Medical Examinar mant be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes. 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cul	Hispanic Origin? () ban, Mexican, Pue		14	Race - Americ Black, White,	an Indian, etc.	
Maryiand z i z i 3-0036	ithin 72 houne.	Completed	15. Decedent's Education of Specify only highest grades Elementary/Secondary (0-12)		(Give		upation a during most of wo ed)	orking		of Business/In	dustry	
7	fygier fygier her th	S	11-Grad. 17. Father's Name (First, Middle, Last,		пош	emaker	10 Markada Na	- Circh Baidele				····
yanıc	Mental H Mental H mrked oti atic ever	To Be	Harry Thomas					me (First, Middle, et Bowe		umame)		
Mar	alth and alth and 27 is m		19a. Informant's Name/Relationship (Beverly Adams,		1		nt and Number or R					29
baltimore,	Pages 1 a ant of He nt: if item y or other		20a. Method of Disposition 1) □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	cemetery, cren	sition (Name of natory or other place Cemetel	1 11/	Date 11/2006		tion - City or To		MD
	permit. F Depertme Importar any injur		21. Signature of Funeral Service Licer				ress of Facility Fr n St., Fe	amptom			_	P.A.
			23a Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.						110 40	Approximinterval Bi	ate etween
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a context)		eer					year	
9,00,	Physician: The law requires thet the death certificete be executed this certificete has been signed by the attending physicien and rai director, page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consect Due to (or as a consect d.								
r.C. box o	es thet the death certific igned by the attending p be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnand Other (specify)	су		236	d. Date of delive Month	ory Day	Year
ras, r	quires thet n signed b uld be deta	Ď	Part II. Other significant conditions of	contributing to death but not re-	sulting in the ur	nderlying cause g	iven in Part I.		obacco use Yes 2□1	contribute to the	ne cause of	
Hecords,	Physician: The law require this certificete hes been si ral director, page 2 should t	Completed								24b. Were auto prior to co death? 1 \(\sum Yes\)	npletion of	
<u> </u>	stan: entific octor,	Be	25. Was case referred to medical examiner?					ath (Check only o	эле)			
5	hysi ihis ca il dire	ဂ္	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐		30 00		Home 5 Resi	dence 6	Other (Specif	v)	
DIVISION OF VITAL	Attending P r death. ector: After t by the funera	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1	28b. Time of Injury	W	ury at ork? ☐Yes 2☐No	28d. Describe I	now injury o	occurred		
<u>=</u>	tel or Attend is efter death al Director: , ed in by the f	Certification:	3 Suicide 6 Could not b		iome, larm, str fy)	eet, factory, office		28l. Location (City or Tou		Number or Rura	l Route Nu	ımber,
	To the Hospitel or Attending in within 24 hours eiter death. Vithe Funeral Director: After completely filled in by the funer	Medical (29a. Certifier 1. Certifying Pt (Check only one) 2 Madical Exam	nysician: To the best of my kn niner: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred at the vestigation, in my	time, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) ar date and pl	nd manner as stace, and due to	ated. the cause)(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier				ise number			signed (Month,	Dey, Year)	-
	-		16 600	No.		Hoo	いくつっつ	_	Nov	6th;	200	<u>د</u>
				o. 3304 Hay	Iman I	Print) Pr. Feder	ralsburg,	md. 21	632			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	freed 1						

06-08388 James Monard

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 36347 1- For State Certificate of Death Registrar Decedent's Name (First_Middle Last) Physician/ 2. Date of Death Month Day November 5, 2006 Medical Examiner Thomas Monard 1142 hrs James 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c County of Death Ridgely Air Park Ridaely Caroline 5. Social Security Number 6. Sex 7. Age (In yrs_last birthday) If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director Country) MD 1 X M 08/07/1945 217-42-2365 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location ì 10d. Inside City Limits Caroline MD Ridgely or items 23a or 28a-f show must be notified at once. 1 Yes 2 X No hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24276 21660 U.S.A. Race Track Road Funeral 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? Never Married 2 X Married White etc. 1 X Yes White 3 Widowed Divorce f Yes, Give Year more, MD 21215-0036

Pages I and 2 should be filed within 72 hours after near of Heath and Mental Hygiene ant. If Item 27 is marked other than "natural"; rother trannarie event, the Medical Examiner. 1 Yes 2 X No specify: Specify N/A \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HVAC Mechanic Petroleum Industry 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ralph Monard Jane Giddings æ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24276 Race Judith K. Monard / spouse Track Road; Ridgely, MD21660 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Date crematory or other place) Burial 2 X Cremation 3 Removal from State mportant: Donation 5 Other Specify 11/07/06 Chester, MD Chesapeake Cremat.Cntr 21. Signature of Funeral Service Lice 22. Name and Address of Facility Fleegle and Helfenbein FunHm; 106 W.Sunset Ave; FO Box 160; Greensboro, MD 21639 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical a Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical tending physician a use as the burial -1 UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ፩ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 ✓ Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene ို ✓ Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Nov 5, 2006 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject pilot of plane that crashed Natural 1130 brs 1 Yes 2 V No Pending To the Funeral Director: 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Ridgely Air Park, Ridgely, MD (Specify) Municipal Airport Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 6, 2006 30-Name and address of person who comp eted cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month) State Day Year) 32. Registrar's Signature Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36348 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** J- Mason amela 4:02 AM 3 2006 OCT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of MD Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2√√x 48 Director 220-68-9676 \$ept. 3, 1958 Maryland Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notifled at 10a. State 10d. Inside City Limits MD Caroline 1 Yes 2 No Funeral Director Federalsburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r Pages 1 and 2 should be filed within 72 hours after death with 3599 Laurel Grove Road United States 21632 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes -2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Plastic Elementary/Secondary (0-12) College (1-4or 5+) Assembly Manufacturing 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred A. Fletcher Douglas Clarke 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 6 3 2 19a. Informant's Name/Relationship (Type. Print) 3599 Laurel Grove Rd., Fede<u>ralsburg,</u> MD Herman Mason/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Financial Insportant: If Ite any Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Federal Hill Cem. 11/04/06 | Federalsburg, MD 21. Signature of Funeral Service Licensee

Multure 4 22. Name and Address of Facilitramptom Funeral Home, P.A. Michael Iskon 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis - severe Physician disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner multiple myeloma Sequentially list conditions, furth, leading to intercept cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an s certificate has b irector, page 2 s autopsy performed' To the Hospital or Attending Physician: this certific ral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t
completely filled in by the funera Certification: 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

2006

31. Date filed (Month, Day, Year)

32. Registrar's Signature

5. Greene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2/10/1

Oct-31, 2006

Baltimore, MD 2120

		ľ	1 - State Registrar	State of	of Mary	/land / l		nent of F cate of			lental Hy	giene Reg. No.	ZUI	16	36	349
	3		Decedent's Name (First, Middle, Last)								2. Date of De	ath Day		ear	3. Time of	Death
	Physicia /Medic		Marg	aret H	I. Mar	ge					Novembe		20		0815	A M
D.	Examin		4a. Facility Name (If not institution, give					City, Town, o	r Location o	of Death		4c.	County of	Death		
* *			Chestertown Nursing and					Cheste		-			Kent			
	Funeral		5. Social Security Number 6. Sex	: M 2∭0 F		n yrs. last bi		Inder 1 Year oths Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da NOV 24,	h y, Year)		Coul	place (State ontry)	
	Director		186-16-3877 Usual Residence of Decedent		83		113.				NOV 24,	192	2.2	Peni	nŝy1va	nıa
1	Na Na		10a. State 10b. County		10	c. City, Tow	n or Location	n							10d. Inside C	ity Limits
1	Mary	to	Maryland Kent			Rock	Hall								1 💢 Yes	2 No
4	or 28	Director	10e. Street and Number				10	f. Zip Code				10g. Citi	zen of Wh	at Cou	ntry?	
	23a c	<u>a</u>	20693 Bayside Ave	nue				21661	L			Uı	nited	Sta	ates	
	ems dee	Funeral	11. Marital Status	12. Was Dec Armed F		r in U.S.	13. Was I	Decedent of H	lispanic Ori an, Mexicar	igin? (Spe	ecify Yes or No Rican, etc.)	-		Americ White,	cen Indian, etc.	
9	or it	by F.	1 Never Married 2 Married	ff Yes, G	2 XNo		10 Y	es 21X No	Specify:				Specify:	Y 79	•	
	tural'	g pa	3 Widowed 4 □ Divorced 15. Decedent's Edu	Year or I	Dates:	169	Decedent's	Usual Occup	ation			16h Ki	nd of Busi	Whi		
2	2/ ni	Completed	(Specify only highest grad	ocompleted,		100	(Give kind	of work done OT use retire	during mos	t of work	ing	100. K	110 01 0031	11033/111	dustry	
7	iene.	E O	Elementary/Secondary (0-12)	Colfege	(1-4or 5+)		Homen	naker				In	Her	Own	Home	
9	should be lied within /2 hours atter deeth with the Maryland and Mental Hygiene. Ind Mental Hygiene. In marked other than "natural" or Items 23a or 28a-f show imarked other than "natural" or Items 23a or 28a-f show imartic event, I've Madical Eservical must be reculted at	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	e (First, Middle,	Maiden	Sumame))		
land	Alenta rked ric ev	To B	unknown Cres	well					Li11	lian	uı	nknov	٧n			
ָם ב	and h		19a. Informant's Name/Relationship (Ty				_				al Route Numbe					
Σ :	end salth n 27		James Dominick Ma	rge/Sc					Avenu		Rock Ha					
9 .	permit. Peges 1 and 2 should be filed within 72 hours after deein with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I important: If them 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	emoval from		cemete		y or other pla	11	loven	oate ober		ocation - C VOOd ,	ity or To	own, State	
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g	Departition Depart		21. Signature of Funeral Service Licens	90			Hick.	ne and Addre	for I	Fune	rals, P eet, El	. A .				
18	4024 W		23a. Part1. Enter the disease, or compl	13L	مان المعالمات	dooth Do							, Mar	yla	nd 219 Approxima	
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on	each line.						12.1				Interval Bel Onset and	ween
F	hysician /Medical		disease or condition resulting in death)					457	RTI	FAI	LURE	-			710	ear
⁵ 1	Examiner			Due to	o (or as a c	onsequence	01):									'
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ة خ	ertific ling p e as l	Mec	IF FEMALE:		4. 1000 4											
o n	death o	Physician/Me	23b. Was decedent pregnant in the past 12 months?		birth 2	Fetal deatl		pic pregnanc	у				23d. Date Mont			Year
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7.	requires that the een signed by th hould be detache		Part If. Other significant conditions co	ntributing to	death but n	ot resulting	in the underh	ying cause gr	ven in Part I	1.	23e. Did t	obacco u	ise contrib	ute to t	he cause of	death?
S	iw requires that s been signed to should be deta	d by	DEMENTIA	ALZI	HEIN	IENS	741	E			10	Yes 2	□No 3	☐ Prot	bably 4	Unknown
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	ilcien: Th certificate rector, pag	e C	25. Was case referred to medical						26 Place	e of Deat	1 ☐ Yes h (Check only o	2 72-No	1 1 1	Yes	2 No	
>	ysicie s cert direct	To B	eyaminer?	Hospitaf:	fnpatient	2 🗆 ER/O	utpatient 3	DOA Ot			me 5□Resi		6 Other	(Specil	fv)	
0	g Phy er thi		27. Manner of Death	28a. Date	e of Injury onth, Day Y	28b.	Time of Injury	28c. Inju			28d. Describe				,,	
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DIVISION	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plac	ce of Injury ding, etc. (- At home, f	arm, street, i	actory, office			28f. Location (or Rura	al Route Nun	ber,
ם	itel o															
	Hosp 4 hou Fune ely fii	edical	29a. Certifier Certifying Phy (Check only 2 Medical Exami	ner: On the	basis of ex	amination a	e, death occ nd/or investig	urred at the tigation, in my	me, date ar opinion, dea	nd place, ath occur	and due to the red at the time,	cause(s)	and man	ner as s	stated. o the cause(:	s)
	To the Hospitel or Attending Physicien: In 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	Med	one) 29b. Signature and title of certifier	and ma	nner stated	1.		29c. Licen			· · · · · · · · · · · · · · · · · · ·				Day, Year)	
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	W		30. Name and address of person who of Helen Noble, M.D.,						200t -	a. t. - :			01/0	0		
	Sta	ate	31. Date filed (Month, Day, Year)	32.	Registrar's	Signature	DULLE	را و المراد <u>:</u> م المراد	iester	LOWE	i, Mary	and	2162	Ų		
	Regist		MOV 1 6 2	306	3.0.	15	600	320								

State of Maryland / Department of Health and Mental F	ygiene Reg. No. 2006 36350
1. Decedent's Name (First, Middle, Last) 2. Date of	Death 3. Time of Death
Physician Month Month Nover No	nber 4, 2006 2:30 A M
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
Chapel Hill Nursing Center Randallstown	Baltimore
OCO OL 1256 LIM ZLAF	Day, Year) Country)
Director 220-34-1476 96 Yrs. Oct.	27, 1910 Pennsylvania
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Garrett Oakland	1 Yes 2 XNo
The state of the s	10g. Citizen of What Country?
26 River View Terrace 21550	United States
26 River View Terrace 21550 11. Marital Status 1 Never Married 2 Married 2 Married 2 New Port New Por	No- 14. Race - American Indian, Black, White, etc.
1 □ Never Married 2 □ Married 1 □ Yes 2 ②No If Yes, Give 1 □ Yes 2 ☑ No Specify: Year or Dates:	Specify:
	16b. Kind of Business/Industry
(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)	Too. Time of Dusiness maustry
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	Own Home
Tr. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	lle, Maiden Sumame)
George VanAsdalan George VanAsdalan Susan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Numb	Speidel
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Number or Rural Route Numbe	nber, City or Town, State, Zip Code)
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) Nancy Neveker, Daughter 20a. Method of Disposition 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 18. Mother's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) Nancy Neveker, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date)	
20a. Method of Disposition 20b. Place of Disposition (Name of cermetery, crematory or other place) 1 \(\mathbb{Z}\) Burial 2 \(\mathbb{C}\) Cremation 3 \(\mathbb{R}\) Removal from State 4 \(\mathbb{D}\) Donation 5 \(\mathbb{O}\) Other (Specify) Hoyes Cemetery 11/07/2006	20c. Location - City or Town, State
4 Donation 5 Other (Specify) Hoyes Cemetery 11/07/2006	
	Durst Funeral Home
21 N. Second St. 23a. Part1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respirator	, Oakland, MD 21550
shock, or heart failure. List only one cause of each line.	Interval Between Onset and Death
Physician (Medical fields) (Medical fields) (Medical fields) An immediate Cause (Final disease or condition resulting in death) An immediate Cause (Final disease or condition resulting in death) An immediate Cause (Final disease or condition resulting in death) An immediate Cause (Final disease or condition resulting in death)	Tear)
Examiner	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	
f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
Cause (Disease or injury that intitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
W IFFEMALE:	
IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 12 No 9 Unknown Unkn	23d. Date of delivery Month Day Year
1 Yes 2 WNo 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Di	
t doe 1	-
Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. D	tobacco use contribute to the cause of death?
Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. D	d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Diagram of the part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. W	d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Part II. Differ significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1	d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Is an opsy prior to completion of cause of death? 2 No 1 Yes 2 No 1 Yes 2 No 1
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			State of Maryland / Dep		lental Hygie	ne	36351
			1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg 2. Date of Death	. NG. UUO	3. Time of Death
	Physicia		IRENE MARLIN		October 2	Day 2006	8:30 A M
	/Medid Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
ı			5656 West Mt. Aventine Road	Indian Head		Charles	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday. 1 M 2 N F 84 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y Aug. 31,	9. Bird 1922 Mar	thplace (State or Foreign ountry) 'Y land
			Usual Residence of Decedent		Aug. 31,	1322 1101	yrana
	arylan ahow	Ļ	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	As Mark	ecto	Maryland Charles I	ndian Head		. Citizen of What Co	1X Yes 2 No
	3a or	Funeral Director	5656 West Mt. Aventine Road	10f. Zip Code 20640	109		ountry?
	death	nera		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
0	or Ita	y Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☒ No Specify:	Hican, etc.)	Black, Whit	
3	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Dece	edent's Usual Occupation	16	b. Kind of Business	White
	n "na Nedic	plet	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired)	ing	o. Kind of Business	industry
7	ad with	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Own Hom	1е
<u>a</u>	be file	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai e A. Aist		
Z	thould d Mer marks matic	2	Edgar L. Roby 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Run			Zin Code)
2	nd 2 salth ar 27 is rrau			West Mt. Aventine			
c G	es 1 a of Hez		20a. Method of Disposition 20b. Place of Disp	osition (Name of	Date 20	c. Location - City or	Town, State
altillo	Pagiment ment tant: I		4 Estimator 5 Estimat (observy)	ans Cemetery 11-1.		eltenham,	
מ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f ahow any injury or other traumatic avent, the Medical Examinar must be notified at once.		1 101210	2. Name and Address of Facility Huntt Funeral Home		d Washing . Waldorf	gton Rd •, MD 20604
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			-	Approximate
	Physician		Immediate Cause (Final disease or condition	ell Leuke	ounia.		Interval Between Onset and Death
	/Medical Examiner		resulting in death) a. Due to (or as a consequence of):				
	ZXUIIIICI	-	Sequentially list conditions, frany, leading to immediate b. Due to (or as a consequence of):				
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
Ď	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):				
00/0	cate be	dicat	d				
ם מא	that the death certificed by the attending podetached for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	livon
<u> </u>	death e atter d for u	Physician/Me	1 ☐ Vas 2 ST No. 1 ☐ Vas 2 ST No. 1 ☐ Vas 2 ST No. 1 ☐ Vas 2 ST No. 1 ☐ Vas 2 ST No. 1 ☐ Vas 2 ST No.	□Ectopic pregnancy □ Other (specify)		Month	Day Year
5	at the by the	hys	9 Unknown				
Ž,	w requires that s been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.			the cause of death?
Spros	been	ompleted				2 No 3 Pr	
ŭ	aician: The law certificate has b irector, page 2 s	mp			24a. Was an autopsy performed	d? death?	atopsy findings available completion of cause of
N I I		e C	25. Was case referred to medical	26. Place of Deat	1 Yes 2V	No 1 □ Yes	2 □ No
> 5	> .0 0	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other		e 6 Other (Spec	cify)
_	ng ffer iner		27. Manner of Death 1 Shatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how	injury occurred	
JIVISION	death ctor: / / the f	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st	M 1 Yes 2 No	28f Location (Stree	et and Number or Ru	ural Route Number
2	al or A safter Il Dira	Certification	4 Homicide determined building, etc. (Specify)	noot, lagory, office	City or Town, S		ar risals remoti,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edical (29a. Certifier Check only 2 dedicel Examiner: On the basis of examination and/or in	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the caus	e(s) and manner as	s stated.
	o tha eithin 2 o the omplet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Monti	
	⊢≯⊢ŏ		1 1x Marhon	02835) 1	0/30/6	. (
(30. Name and address of person who completed cause of death (Item 23a) (Type,	, Print)		13-1	0
	BID		31. Date filed (Month, Day, Year) 32. Egistrar's Signature	Lattete	- 1	06 0	646
	Sta Registr		31. Date filed (Month, Day, Year) OCT 3 0 2006 32. Agistrar's Signature	berk			

			For State		State	of Maryl	and / Dep				ental Hy	giene		
			1. Decedent's Nam	- /5: 1 11:	- (4)		Ce	rtificate	of Death	7		Reg. No.	2006	36352
	Physicia /Medic		Flo	rence	Merlo						2. Date of De Month Octobe:	Day	, 2006	9:15 p _M
2	Examin	er	4a. Facility Name (. 0	,			wn, or Location	of Death		4c. Co	ounty of Death	
			5. Social Security I		Station C		rs. last birthday		dbine	er 24 Hrs.	8 Date of Birt	h	Howard	lace (State or Foreign
	Funeral Director		149-22-9	093	1 M 2 M F	83			Days Hours		8. Date of Birt (Month, Da 12/21/	y, Year) 1922	Cour	ed Kingdom
	land ow		Usual Residence of 10a. State	10b. County		10c.	City, Town or L	ocation.					1	0d. Inside City Limits
	Mary a-f sh filed	tor	Md.	How	ard		Wood	dbine						1 ☐ Yes 2X No
	or 28	Director	10e. Street and Nu					10f. Zip Co	ode			10g. Citizer	n of What Cour	itry?
	ath w		848	The Ol	d Statio				21797				USA	
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	by Funeral	11. Marital Status 1 Never Mar		ried Armed 1 ☐ Ye If Yes,	ecedent Ever i Forces? s 2X No Give	n U.S. 13	Was Deceder If Yes, specify 1 ☐ Yes 25	Cuban, Mexica	an, Puerto I	cify Yes or No- Rican, etc.)		Race - Americ Black, White, becify: Whi	etc.
	72 hour natural' dical Ex		3€ Widowed	15. Deceder	it's Education		16a. Dec	edent's Usual (Occupation				of Business/Inc	
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1	filed within Hygiene. Ither than "		12y		(and)		Med	ical Ad			(Final Asidata		edical	
	ed all be	To Be		e Sawfo							(First, Middle, Cockhea		rname)	
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2	and 2 ealth n 27 i				rlo/daugi		848	The Old	l Stati	on Ct	. Woodk	oine.M	id.2179	7
5	Pages 1 nent of H int: If Iter		20a. Method of Dis		3 □Removal fro	m State	 b. Place of Disp cemetery, cre 	osition (Name ematory or othe	of er place)	D	ate	20c. Locat	ion - City or To	wn, State
	# 문원증		4 □ Donation 21. Signatore of F	5 Other (S		M€	etro Cre				/2006	Caton	sville	Md. F.H.Inc.
3	permi Depa Impo any ir) (h	dre	P. Ome	VW _	100845 4	112 010	d Colum	bia P	ike Ell	icott	City,	/d. 21043
	AB =		snock, or ne	an fallure. List	complications that only one cause or	t caused the d n each line.	leath. Do not er	nter the mode of	f dying, such a	s cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
•	Physician /Medical		Immediate Cause disease or condition resulting in death)	on	a	erebra	ovas al	er Hc	cider	<u></u>			d	Conthi_
	Examiner				L C	o (or as a con	sequence or):	Lie	0.0.		Do	02 1		11- H-
	p ±	ner	Sequentially list of if any, leading to it cause. Enter Und Cause (Disease of	onditions, mmediate erlying	Due Due	o (of as a con	sequence of):		Just	1	7 75	Va Sa	/	Monico
	and -trans	Examiner	Cause (Disease o that initiated event resulting in death)	r injurÿ S Last	C	o (or as a con	d car	Sions	pu Ky				/	Montes
5	icate be executed physician and s the burial-transit				l .	o (or as a con	sequence on.	/ /	/					
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	eath certific attending p for use as	an/M	IF FEMALE: 23b. Was deceder			outcome pf pre		□Ectopic preg	nancv			23d	. Date of delive	*
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 1 ☐ Yes 2 9 ☐ Unknow	∑ No		gnant at time		Other (speci					Month	Day Year
5	w requires that the d been signed by the should be detached	by Pł	Part II. Other sign	ificant conditi	ons contributing to	death but not	resulting in the	underlying caus	e given in Part	1.	23e. Did to	obacco use	contribute to th	e cause of death?
5	require sen si										1 🗆 \	res 2□N	No 3 ☐ Prob	ably 4 Unknown
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3			25. Was case refe	rred to medica	1				OF Place	o of Dooth	1□ Yes	2X No		2□ No
	ysicia is cer direct	o Be	examiner? 1 ☐ Yes 2 🔀		Hospital:	☐ Inpatient 2	2 ☐ ER/Outpatie	ent 3 DOA	Other:		(Check only one 5% Residence		Other (Specify	()
2	iding Physician: th. : After this certifics tuneral director,	on: T	27. Manner of Dea	th 5 ☐ Pendir		te of Injury onth, Day Yea	28b. Time Injury	of 28c.	Injury at Work?		8d. Describe h			
2	ttendi leath. tor: A the fu	catio	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	gation not be			M	1 ☐ Yes 2 ☐					
5	after of Direct of in by	Certification:	4 ☐ Homicide	determ	sinod 200, Fla	ce of injury - P Iding, etc. (Sp	At home, farm, s ec <i>ify)</i>	reet, factory, o	ffice	2	8f. Location (S City or Tox	Street and N vn, State)	lumber or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)	1X Certifyir 2☐ Medical	ng Physician: To t Examiner: On the	he best of my basis of exan	knowledge, dea nination and/or i	nth occurred at necestigation, in	the time, date a my opinion, de	and place, a	and due to the ed at the time,	cause(s) an date and pla	d manner as st	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and	d title of certifie		otatou.		29c. L	cense number			29d. Date _j s	igned (Month,	Day, Year)
)			1 Tu	Mo	UL	MO		0	0058	137	,	10/2	0/06	
)() P		30. Name and add	ress of person	who completed ca	use of death (Item 23a) (Type	Print)	+ 307	Les	ct	char	MA	21157
	Sta		31. Date filed (Mo			Registrar's Si		4	1		71 min	556/	1010	/
E	Registr	ar		OCT 3	1 2006	Color	K 1	mark ;						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygions

			Otate of Ivia	- ylarid /		ificate of		u Meniai my	Reg. No. 🤈	000	2605
	sician edical	Decedent's Name (First, Middle, L GEORGE HENRY M	ALYAN					2. Dete of De Month OCTOBE	Dev	2006	3. Time of Death
Exa	miner	4a Fecility Neme (If not institution, git 227 HORSESHOE RO	,				4b. City, Town, QUEEN	or Location of Deat	h 4c. Coun	ty of Deeth	
Fune Direct			1 1 M 2 T E	(In yrs. lest l		If Under 1 Year Months Days	r If Under 24 i		th ay, Year)		ece (State or Foreign
death with the Maryland me 23a or 28a-f show		10a. State 10b. County		10c. City, To	wn or Loca	ition				10	d. Inside City Limits
the Me	Director	MD QUEEN 10e. Street end Number	ANNE	QUEE	N ANN						1 ☐ Yes 2 No
3a or	j	227 HORSESHOE RO	AD			10f. Zip Code 216	57		10g. Citizen of		y?
permit. Pages I and 2 should be filed within 72 hours after death with the Manylan Department of Health and Manual Hygiens. Proportant: I flem 27 is marked other than "naturel", or items 23a or 28a-1 show any Injury or other traumatic event, the Mancel Examine mail be notified as	y Funerai	11. Marital Status 1 Never Married 2 Merried	12. Was Decedent Ev Armed Forces? M☐ Yes 2 ☐ No				Hispanic Origin? pan, Mexican, Pu	(Specify Yes or No verto Rican, etc.)		ace - Americar ack, White, et	
2 hour	ed by	3 Widowed 4 □ Divorced 15. Decedent's E	Yeer or Dates:	WWII					Spec	MHTT	
d within 72 hours after giene. In than "naturel", or its	Completed	(Specify only highest grant Elementery/Secondary (0-12)	College (1-4or 5+)	16		nt's Usual Occu nd of work done NOT use retire	pation during most of t ed)	working	16b. Kind of I	Business/Indu	stry
semit. Pages 1 and 2 should be file beamit. Pages 1 and 2 should be file beath and Mental Hy mportant: if item 27 is marked other iny injury or other traumatic event,	To Be C	17. Father's Neme (First, Middle, Last VERDON MALYAN)					Name (First, Middle,	Maiden Suma		
12 sho h and le m		19a. Informent's Name/Relationship (Rurel Route Number		n, Stete, Zip C	ode)
1 and Health Iem 27 other to		JEFFREY MALYAN/SO 20a. Method of Disposition				ORSESHOI on (Name of	E ROAD,	QUEEN AND		21657	
it. Pages rtment of rtant: If It		1 ☐ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specifical Signature of Funeral Service Licer	Removal from State y)	cemete	ery, creme!	CREMAT	ce) LON	Date 10/31/06	20c. Location TEVENS		
pemit. Departm Importal	500	V/ // W	1671		FEI	LOWS H	ELFENBET	N & NEWNA	M FUNE	RAL HON	Æ, P.A.
Physicia /Medica Examine	al er	23a. Pert1. Enter the disease, or com shock, or heart failure. List only Immediate Ceuse (Final disease or condition resulting in death)	· Prost		lanc	er	ig, such as card	lac or respiratory ar	rest,	450 L)	pproximate iterval Between miset and Death
The law requires that tha death certificate be executed at a been signed by the attanding physician and page 2 should be datached for use as the burial-transit	√Medicai Examiner	Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	C	e to (or es e							
death ne attar	Physician/	Part II. Other significant conditions co	entributing to death but no	ot resulting i	n the unde	dvina cauco aiv	on in Bart I	OOL DIAL			
es that tha igned by the be datach	by					Tyring Cause giv	enin Faiti.		es 2 No	3 ☐ Probab	e cause of death?
To the Hospital or Attending Physician: The law requires that tha death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be datached for use	Completed							24a. Was a perfor	n autopsy med?	availa	autopsy findings ble prior to letion of cause oth?
n: The icata h								1 🗆 Y	es 2 No	1 🗆 Ye	es 2 No
ralcia: s certii directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospitel: 1 ☐ Inpatient	2□ ER/Ou		Othe		eath (Check only on			
ading Phy ath. r: Aftar thi		27. Menner of Death 1 Anaturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Ye		Time of njury	28c. Injun Work	4 □ Nursing at	Home 5 X Reside			
Ital or Atterned Italian de Itali	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - building, etc. (S	pecity)				28f. Location (St City or Town	i, State)		
the Hosp in 24 hot the Funei tpletely fil	edic	one)	sician: To the best of my ner: On the basis of exa and manner stated.	knowledge mination end	, death occ d/or investi	curred at the tim gation, in my op	e, date and plac pinion, death occ	e, and due to the ce urred at the time, da	euse(s) and ma ate and place, a	nner es stated and due to the	d. cause(s)
Will To	- 1	29b. Signeture and title of certifier	10/1. A			29c. License		2	9d. Date signed	(Month, Day	, Year)
500		John Mighe	Cang M.D			D52	824		ctober	- 30, 2	2006
	,	30. Neme end eddress of person who co	inpleted cause of deeth	(Item 23a) (250	Type, Print	NAVA	AL HEAL	TH CLINE NNApolis	MD	214	03
St Regist	late	31. Dete filed (Month, Day, Year) OCT 3 1 201	UZ. Jegistiei s	Signature	1	. 4					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year RRA /Medical 06 alisbury Facility Name (If not institution, give street and number 4c. County of Death Examiner Keninswa Kegiona medicar Center Vicamico If Under 1 Year | If Under 24+ Date of Birth (Month, Day, Social Security Number 9. Birthplace (State or Foreign **Funeral** Year) Months Days Hours Director MARKAMD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits Ma 1 ☐ Yes 2 No Funeral Director Comico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify. 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Concrete Elementary/Secondary (0-12) College (1-4or 5+) OWNER-Richard Murray's Concrete $^{\prime}$ \sim Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ ar Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MURRAY WALNUT TREE Rd. SAlisbury, md 21801 Shella 27345 20a. Method of Disposition
1 Burial 2 □ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-30-06 Signature of Juneral Service Licens 22. Name and Address of Facility Bennic Smith FUNELAL HOME W. Isabella Street SALISBURY 23a. Part1. B ter the dise shock, o heart failur e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or condition resulting in death) **Physician** er osmolar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ሺ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 7 No Hospital: Other: 4 \(\tag{Nursing Home} \) 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day Year) 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of cartiful 29c. License number 29d. Date signed (Month, Day, Year) 10/26/06 HO059368 who completed cause of death (Item 23a) (Type, Print) 100 B. Carrill

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT 3 0 2006

32. Registrar's Signature

			For State Ragistrar	State of Maryla				ealth a Death	nd Me		giene Reg. No. 2	2006	363	5.5
	Physici /Medio		1. Decedent's Name (First, Middle, Last, P	Muir						2. Date of Dea Month	Day 27	Year 06	3. Time of Deal	th M
	Examin	er	4a. Facility Name (If not institution, give Coastal Hospice 6. Se) 5. Social Security Number 6. Se)	at the Lake	. last birthday)	So	Town, or List	Location of		B. Date of Birt	b	ounty of Death U1 C0 m		eian
	Funeral Director			м 2 % F 68	Yrs.	Months	Days	Hours	Min.	(Month, Da) 2/9/19:	y, Year)		place (State or For htry) Yland	
	the Maryland 28a-f show	Director	10a. State 10b. County Maryland Wicomic 10e. Street and Number		Salisk	oury	p Code				10a Citize	en of What Cour	0d. Inside City Lir 1 ☐ Yes 2 🖔	
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980	72 hours after death with the Maryland neturel', or terms 23s or 28s-f show alest Examinat must be motified at	by Funeral	11. Marital Status 1 Never Married ZX Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 Yes		ispanic Orig n, Mexican, Specify:	in? (Spec Puerto R	rty Yes or No- ican, etc.)		Black, White, pecify: W		
21215-0036	within 72 ene. then "ne	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)		dent's Usu kind of wo DO NOT u	ork doné d ise retired	ation during most	of working	9		of Business/In	dustry	
Maryland 2	B a b ≥	To Be C	17. Father's Name (First, Middle, Last) Earl Phillips							(First, Middle, skridge	Maiden S			
	1 and 2 sh Health and em 27 is m ther treum		19a. Informant's Name/Relationship (Ty William Muir/husba 20a. Method of Disposition	nd	304	179 Ca	annor	Dr.,		isbury.	, MD	Town, State, Zip 21804 ation - City or To		
Baltimore,	t. Pages rtment of rtant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Coars	Sa	cemetery, creatisbury	y Cre	mato	ry 1	LO/30		Sal	lisbury		_
Ä	Depa Impo		23a. Part1. Enter the disease, or compl	mey (F)P	5	01 S	now E	Hill R	d., S	Salisbu	ary,	MD 2180	4	n
	Physician /Medical Examiner		shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	CONGRSTI Due to (or as a conse				HLU1 174		-		AGR	Approximate Interval Between Onset and Death	
8760,	death certificate be executed e attending physicien and nd for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive of the consecutive of t	equence of): OBSTA						240	ASRASI		
P.O. Box 68	death certific e attending p od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	tal death 3	⊒Ectopic p ⊒ Other (s _i					23	d. Date of delive Month	ery Day Year	
	The law requires thet the set has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions con	ntributing to death but not re	esulting in the u	inderlying (cause give	en in Part I,				o contribute to the	ne cause of death ably 4 Dunkno	
Vital Records,		Completed							_	24a. Was autop perior 1 Yes	an sy rmed? 20 No	prior to co death?	psy findings availamptetion of cause	able of
Vita	Physicien: Th this certificete rai director, pag	Be	25. Was case referred to medical examiner?	lospital:			Othe Othe	20		(Check only o				
ō	ding After fune	atlon: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident Investigation	dospital: 1 Impatient 2[28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury Work	4 🗆 Nur	28	e 5 ☐ Resid		□Other (Specif	y)	
Division	tal or Attandi rs after death. el Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factor	y, office		28	3f. Location (S City or Tow	Street and i	Number or Rura	l Route Number,	
	To the Hospital or, within 24 hours after To the Funerel Director completely filled in E	edical	29a. Certifier 1 Certifying Phy. (Check only one) 1 Medical Exami	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred ivestigation	at the time, in my op	ne, date and pinion, death	place, an	nd due to the d d at the time,	cause(s) a date and p	nd manner as s lace, and due to	tated. the cause(s)	
	To th To th	Me	29b. Signature and title of certifier			29	c. License	number			29d. Date	signed (Month,	Day, Year)	
	08		-8C1	m	- 20 1 =	Details	D00	584	10		10,	128/06	5	
	00	, ili	30. Name and address of person who co	S W 266	om 23a) (Type, ARRI)	Print) WWt	a or	CT.	SA	บราง	RY	mp.	2180)	
	Sta Registi		31. Date filed (Month, Day, Year) OCT 3 0 20	empleted cause of death (Itel) S 26 266 32. Pegistrar's Sign	nature	parts	p							

DHMH 17 Rev 1/2001

ORIGINAL

				e Type or Prid State of M		d / Dep	artment of	Health	and Me			_egible.	
			1 - For State Registrar			Ce	rtificate of	Deat			Reg. No.	2006	36356
	Physic		1. Decedent's Name (First, Middle,	RENEE		MAR	TIAL		2	2. Date of Dea Month VOVers	Day	8 2000	3. Time of Death 0537 PM
	/Medi Examir		4a. Facility Name (If not institution,		.,	11) •	4b. City, Town,	or Location	n of Death	VUYEN	4c. (County of Deat	th
			SHADY GROVE	ADVENTIS		SPITAL			, MARY	<i>I LANI</i>	> Y	MONTG	JOMERY
	Funeral Director		5. Social Security Number None Usual Residence of Decedent	. Sex 7. Ag	je (In yrs. I	ast birthday) Yrs.	Months Days		er 24 Hrs. 8 Min.	Date of Birtl (Month, Day	2006	9. Birt Co Ma	hplace (State or Foreign aryland
	inyland show		10a. State 10b. County		10c. City	, Town or L	ocation						10d. Inside City Limits
	the Ma	Director	MD. Washi	ngton	На	agerst					10- Ciai-		1 ☐ Yes 2 No
	Maith 13a or	ai Dir	20814 Lehmans	Mill RD.			10f. Zip Code 2174.	2			_	en of What Co	ountry?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Modical Examinar must be notified at ance.	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1			Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic C an, Mexic Specif		fy Yes or No- can, etc.)		4. Race - Ame Black, White Specify: W	ncan Indian, e, etc. hite
Maryland 21215-0036	within 72 hou ane. then "nature se Medical E	mpleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire None	pation during mo	ost of working			d of Business/	Industry
d 2	Hygie other	Be Co	17. Father's Name (First, Middle, La	st)			None	18. Mot	her's Name (i	First, Middle,		None Sumame)	
ylan	Menta Menta arked attc ev	ToB	Timot	ny R. Marti	n			L		K. Mar			
Mar	d 2 sho th and th sm 7 is m traum		19a. Informant's Name/Relationship Timothy R. Mart:				ng Address <i>(Street</i> 14 Lehman						
	f Heal for 2 tom 2 other		20a. Method of Disposition		20b. Pl	ace of Disno	eition (Name of	- 1	Dat			ation - City or	
Baltimore,	Page ment cent: If ury or		1 A Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe		Rei Chu	ff Mer rch C	matory or other pla nnonite emetery	1	11/11			rfoss,N	4D.
Ball	permit. Depart Import any inj		21. Signature of Funeral Service Lic	ensee Immlime	m 0	~ 2	Name and Address immerman 5 S. Car	ass of Faci	Son Fu St. G	neral reenca	Home stle	Inc.	17225
	Physician /Medical		23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	mplications that caused by one cause on each line a. Pumo Due to for as	nay	hupon	er the mode of dyin	ng, such a	s cardiac or r	espiratory arr	rest,		Approximate Interval Between Onset and Death
68760,	icate be executed by price in physician and burial-transit constitution in the purial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Resmo			o pathy						24hrs	
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ď.	es that the igned by be detaction	y Pt	Part II. Other significant conditions	contributing to death b	ut not resul	ting in the u	nderlying cause giv	ren in Part	I,	23e. Did tol	bacco use	e contribute to	the cause of death?
ord	w require been si should b	ted	micrognothia,	multiple c	ontro	acture				1 🗆 Ye	es 2 🕅	No 3□Pro	bably 4 Unknown
al Rec	kicien: The law certificate has b rector, page 2 sl	Сотріє								24a. Was a autops perfor 1 ☐ Yes	n ned? 2 No	death?	opsy findings available ompletion of cause of
Vita	ysicien: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Minpatie	at 2015	R/Outpatien	t 3 DOA Oth	or		Check only on		D011	· · ·
n of	ding Phys h. After this funeral di	J: L	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur	v :	28b. Time of Injury		*		. Describe ho		Other (Spec	ny)
ivisio	a at a a	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	on be an Place of lair	ıry - At hon	ne, farm, str		Yes 2□		Location (St City or Town	reet and	Number or Rui	ral Route Number,
۵	To the Hospitel or Atte within 24 hours efter de To the Funerel Directo completely filled in by th		29a. Certifier 17 Certifying I	Physicien: To the best of aminer: On the basis of	of my know	ledge, death	occurred at the tir	ne, date a	nd place, and	due to the ca	ause(s) a	nd manner as	stated.
	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner sta	ted.	on anator in	29c. Licens		000011 0 0			signed (Month)	
	F ≯ F 8		Windrule .	labellom					2				
			30. Name and address of person whe A Kimberly Iak	completed cause of de	eath (Item :	23a) (Type,	Print)	- Di	ive	Rockv	ille.	Maruli	8, 2006 and 20850
-	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 5 2	32. Redistra	ire Signati	Iro A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 11em 20b per fh 8861 11-15-06 VI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9: 30a.^M Carrie Mastrodomenico 2006 Nov. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 24208 Red Rock Lane, S.W. Rawlings
If Under 1 Year | If Under 24 Hrs. Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F Months Days Hours Yrs. 91 Oct. 4,1915 234-38-7803 Maysville, WV Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Allegany Rawlings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24208 Red Rock Lane, S.W. 21557 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Rohrbaugh Gertrude Keplinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Sirk/ Daughter 24213 Red Rock Lane, S.W. Rawlings, MD 21557 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) 11-4-06 Thrush Cemetery Antioch, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

	D		Usual Residence of Decedent												
	lan w		10a. State	Da. State 10b. County 10c. City, Town or Location								10d. Inside City Limits			
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		ect			any	ny Rav			wlings						
	ith t	Director	10e. Street and Nu	mber			1	10f. Zip Code			10g. Citizen of	f What Country?			
	23a		24208 I	Red Rock	Lane, S.W.			21557				JSA	A		
	deg erns	Funeral	11. Marital Status 12. Was D			Ever in U.S.	13. Was	Decedent of H	ispanic Origin? (S	specify Yes or No- to Rican, etc.)	14. Rad	nican Indian,			
9	after	F	1 Never Marr	ied 2☐ Married	1 ☐ Yes 2 📉 N If Yes, Give		1 Yes 2 No Specify:				Black, White, etc.				
93	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Evantment be notified at once.	d by	DewobiW X €		Year or Dates:					Specif	Wh	White			
ABaltimore, Maryland 21215-0036		Completed		15. Decedent's Ed	de completed)	6a. Decedent's Give kind life. DO N	 Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) 			16b. Kind of B	lusiness/	Industry			
212	d withing jiene.	omo	Elementary/Seco	ondary (0-12)	College (1-4or 5	Homemaker			Own			ome			
g	othe ent,	Be C	17. Father's Name	(First, Middle, Last)					18. Mother's Na	me (First, Middle,	Maiden Sumar	тө)			
<u>a</u>	ld be enta ked ic ev	0	Georg	ge Rohri				Cor	trudo V	online	nlinger				
2	mar mat	-	George Rohrbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta										Zin Code)		
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ō	ges It of I			•	Removal from State	ceme	of Disposition etery, cremato	ry or other place	(e)	Bato	200. Location	- City of	TOWN, State		
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	permit. Pages Department of Important: If i any injury or one		21. Signature of Fu	neral Service Licer	ISOB /		22. Na	me and Addre	ss of Facility	mith Fun	eral Ho	ome			
Ş m	207 29		Frank Fruith 85 S. Main Street Keyser, WV 26726												
9			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
	Physician		Immediate Cause (Final Onset and Death,												
	/Medical		disease or condition resulting in death) a. H5 Comment Sepsis												
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	ed tis	Examiner													
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Сап	that initiated events resulting in death)	S 🔳	C. Dun to (or on		no of\:								
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39	rtifica ng pl	Jed	IE EEMALE:												
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e	n: The law icate has l r, page 2 s	ldu								24a. Was autop	sy	prior to	topsy findings available completion of cause of		
<u></u>		Ö	performed?										2 🗆 No		
Vita	sician: certific rector,	Be (25. Was case referred to medical 26. Place of Death (Check of							ath (Check only o	ly one)				
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0	g Phy er this eral c		27. Manner ea	28a. Date of Inju	. Date of Injury 28b. Time of				28d. Describe how injury occurred						
o	Attending Port death. ector: After by the funera	at lo	1 Matural 2 Accident	5 Pending investigation		y rear/	Injury 1		Injury at Work? 1 Yes 2 No						
S	or Attendate death	flca	3 Suicide	6 Could not b	280. Place of Inj	ury - At home	, farm, street.	factory, office				ber or Ru	ıral Route Number,		
Division of	i Diffe	Certification:	4 Homicide determined building, etc. (Specify)							City or Town, State)					
	Hospital 24 hours a Funeral I		29a. Certifier	10 Cartifying Di	ysician: To the best	of my knowle	dan danth	urrad at the ti-	no data and sin-	and due to the	221100(0)		stated		
	Hos 4 hi	ical	(Check only	2 Medical Exar	niner: On the basis of	f examination	and/or investi	gation, in my o	pinion, death occi	urred at the time,	date and place,	anner as	to the cause(s)		

29c. License number

29d. Date signed (Month, Day, Year)

21502

lovember

Cumberland, MD

022006

State Registrar

within 24 hours after death

To the Funeral Director:
completely filled in by the

29b. Signature and title of perities

31. Date filed (Month, Day, Year)

Gary L. Wagoner,

30. Name and address of person who completed use of death (Item 23a) (Type, Print)

2006

5

M.D.

32. Registrar's Signature

925 Bishop Walsh Drive

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment <i>rtificate</i>			nd Me		ene g. No. 2	006	36	358	
F	Physici		1. Decedent's Name (First, Middle, La Angelica Leticia		lina					2. Date of Death Month November	Day	Year 2006	3. Time of 2:14	Death P M	
	/Medio Examin	er	4a. Facility Name (If not institution, giv	e street and number)		4b. City, T		Location ol		VO V CHILDET	4c. Cou	nty of Death	2.14		
	Funeral Director	W	5. Social Security Number 6. S 629-96-6493		(In yrs. last birthday, 5 Yrs.	If Under 1		If Under 24 Hours	Min.	8. Date of Birth (Month, Day, June 26	Year)			r Foreign	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23e or 28e-1 ehow eny injury or other treumatic event, the Medical Examiner must be notified at once.	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes, Give 1 Yes, Care 1 Yes 2 No Specify: Specify:										of What Countries Race - America Black, White, Whit f Business/In 11 Educa name)	nerican Indian, ite, etc. ite s/Industry ucation			
Baltimore, M	permit. Pages 1 and 2 Depertment of Health a Importent: if item 27 is eny injury or other tre		Juan Sanchez Cano]Removal from State by)	20b. Place of Disposemetery, cre Smithsbut	osition (Name matory or oth rg Cres 2. Name and	e of ner place mato Address	ry 11	Da ./8/2	006 S	niths Basfo	burg, ord Fur	Maryla neral H	lome	
	death certificate be executed We ettending physicien and business as the buriat-transit	23a. Part Jendy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Sadse (Final disease or condition resulting in death) a. Hypoxemia Due to (or as a consequence of): b. Respiratory Failure Due to for as a consequence of): cause. Einter Underlying Cause (Disease or injury that initiated events resulting in death) Last Conject Anomalies Due to (or as a consequence of):											Approximation Interval Betto Onset and I	ween	
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	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions of Severe Developmen						S				he cause of d		
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Division of Vital Records,	To the Hospital or Attending Physicien: The within 24 hours effect death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	ation: To Be	4 Homicide building, etc./(Specify) City or Town, State)							nce 6 🗆 (
Divis	ital or Attendurs efter deathurs efter deathurs!	Certification:								eet and Number or Rural Route Number, State)					
	To the Hospital within 24 hours e To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Pl 2 ☐ Medical Exa 29b. Signature and title of ception	nysicien: To the best of niner: On the basis of and manner stat	examination and/or in	ivestigation, i	t the time in my opi	nion, death	place, ar n occurred	d at the time, da	te and plac	manner as s e, and due to ned (Month,	o the cause(s)	
	£3¥8		30. Name and address of person who	completed dura of the) IT	- D2	3651					er 7,			
8	Sta Regist		Ernesto C. Torres 31. Date filed (Month, Day, Year) NOV 1 5 2	32. Begistra	Thomas Jol	nnson l		e, #2	02,	Frederi	ck, M	D 217	'02		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Rag. No Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) October 31, 1:30 **Physician** 2006 James Maguire Nelson, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's 39062 Cedar Wood Court 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1**X**0 M 2□ F Maryland 68 215-36-4888 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or Items 23s or 28e-f ahow the Medical Examinar must be notified at 1 Yes 2\No St. Mary's Director Maryland Mechanics ville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20659 USA 39062 Cedar Wood Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Wes 2 \(\) No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical once. Elementary/Secondary (0-12) College (1-4or 5+) Power Plant Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Beatrice Cecelia Tennyson James Andrew Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Lorraine Nelson / Wife 39062 Cedar Wood Court, Mechanicsville, Maryland 20659 20b. Place of Disposition (Name of cometery crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6, 2006 Helen, Maryland Cemetery 21. Signatore of Funeral Service License Mattingley-Cardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ACVD Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) CARDO MY SPATHY Examiner Sa uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CORONARY ALTERY DIFFE attending physician and for use as the burial-transit Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. ۵ maseres mentus 1 Yes 2 No 3 Probably 4 Unknown Completed PERIMENAR VACCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No Certification: To S C 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tive MI 11-1-06 person who completed cause of death (Item 23a) (Type, Print) MOLYWOOD MD VOLY6 SHAM ASSOCIATES 6.00 Registrar's Signature State Registrar

			1 - For State Registrar	State of	Marylan		artmen rtificat			nd Me	ental Hy	giene Reg. No	21116		360	360	
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	how	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation								ity Limits		
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99	urs al	ğ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 🗆 Yes	2 ∏ No	Specify:				Specify:	Blac	·k		
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	To the Hospitel within 24 hours a To the Funeral I completely filled	lica	29a. Certifier Cortilying Ph	iner: On the bas	is of examina	wiadga, dami ition and/or in	estigation,	at the tim in my op	ia, data and , inion, death	occurred	d due to the at the time,	date an) and manner t d place, and di	as statud ue to the	t. cause(s	i)	
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	Sta		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa		- 1										
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ORIGINAL

DHMH 17 Rev 1/2001

Mary Estelle Noul

State of Maryland / Department of Health and Mental Hygiene 2006 36361 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 8 **Physician** 2006 7:06 pM Rita Dolores Norris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, June 5, 193) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 71 Director 215-34-3269 1935 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo St. Mary's Maryland Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20869 Kimberly Lane 20650 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be itied within 72 hours after to Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iter any Injury or other treumatic event, the Medical Examinations any injury or other treumatic event, the Medical Examina 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) New Accounts Manager Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rosalie Hewitt John Richley Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cornelia Lynn Fuchs / Daughter 20869 Kimberly Lane, Leonardtown, Maryland 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Face Cemetery 13, 2006 Great Mills, Maryland 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 21. Signature of Funeral Service Licensee Michael Kever Hardina 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): infarction Examiner Myoc axdial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien end I for use as the burial-transit MULHIPLE Scierosis Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a d be deteched to 1 ☐ Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 2 Accident nerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Direc 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical To the Function within 2 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 47066 AShan 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVANI D SHAH LEONARDTOWN MD. 31. Date filed (Month, Day, Year) 32. Pajistrar's Signature State NOV 0 9 2006 Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physicisn: The law requires thei the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar		State o	f Man	yland /	Depa	artmen rtificat	t of H e of L	ealth D <i>eath</i>	and M	lental H	ygie Reg.		06	36362
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	5. Social Security Number 052-16-2437		Sex IÄM 2□F	7. Age (la	n yrs. last i 85	Yrs.	If Under Months	1 Year Days	If Unde Hours	Min.	8. Date of B (Month, D AUGUST	Dav Ye	ar) 1921	9. Birthi Coul NEW	place (State or Foreign ntry) YORK
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To Be	MORRIS ORGAN										EDARBAUM		ion obman	.0,	
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	21. Signature of Funeral	Service Licer	1500			11	Name an	d Addres	s of Facil	ty HIN	ES - RIN , STLVER	ALDI	FUNER	AL HON	Έ, INC.
dicai Examiner	23a. Part1. Enter the disc shock, or heart failu trimediate Cause (Final disease or condition resulting in death) Sequentially list condition any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ire. List only	a. RENAL Due to ERNAL Due to C.	CELL (or as a co	CARCIN	OMA e of):									Approximate Interval Between Onset and Death
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Medical Certification:	1 XNaturat 5 ☐ 2 ☐ Accident	Pending investigation Could not be determined	(<i>Mon</i>	of Injury	ear) - At home,	Injury	М		at ? ∕es 2 ☐	No	28d. Describe	(Street	and Numb		il Route Number,
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edical	one)	Medical Exar	nysician: To the miner: On the b and man	best of masis of ex ner stated	amination a	ge, death and/or inv	occurred vestigation	at the tim , in my op	e, date a pinion, de	nd place, ath occurr	and due to the red at the time	cause , date a	e(s) and ma and place, a	inner as s and due to	tated. the cause(s)
≥	29b. Signature and title of	f certifier	Sche	•		MI	290	. License	number 26520			29d.	Octobe		Day, Year) 2006
	30. Name and a dres of PHYLLIS S. SC				h (Item 23a CUTIVE			E. 30	0 ROCI	KVILLE	, MD 20	852			
e ır	31. Date filed (Month, Day	y, Year) 3 1 20	006	legistrar's	Signature	A CO	de								

State

State of Maryland / Department of Health and Mental Hygiene 106 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month. Year **Physician** Uncel 13300 M 2006 STODOS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9 3136 Vages/60 Ver DITTO montromers 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplece (State or Poreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1⊠M 2□F 577-26-8122 82 Director OCTOBER 13, 1924 MARYLAND Usual Residence of Oecedent with the Maryland 10c. City. Town or Location 10b. County 10d. Inside City Limits 10a State or 28a-f show if Heelth and Mental Hygiene. Item 27 Is marked other then "nature!", or Items 23a or 28a-1 shov other treumatic event, the Modical Exemplant must be notified at 1 ☐Yes 2 No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3136 ADDERLEY COURT 20906 UNITED STATES OF AMERICA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates:1944-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONTRACTOR HOME IMPROVEMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Heelth end Mental Hant: If Item 27 is marked of 0 ERNEST VINCENT PURCELL CRISTINA MARY KRAUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA ANN REELEY - NIECE 2707 HIGBEE ROAD, HYATTSVILLE, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Depertment of Important: If ony Injury or once. FT. LINCOLN CREMATORY 11/13/06 BRENTWOOD, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHINES - RINALDI FUNERAL HOME, INC. Vel 11800 NEW HAMPSHIRE AVE, SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVD **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use es the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. F signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete Fo the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA ٩ 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Vatural within 24 hours after death. To the Funerel Director: Al completely filled in by the fu 1 Yes 2 No 2 ☐ Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapfler stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000428 M M mo me 2 2101 metical 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHER, MO DIE N 31. Date filed (Month, Day, Year) 32 Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND #18 per FH11/1/06, BMW, MbCb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 2^{Day}, 2006ar Paula A. PRESENT 4:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Montgomery Hospice Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | June 22, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New York 088-20-9653 80 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Maryland Montgomery Bethesda 1 □Yes 2 □No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5109 Newport Avenue 20816 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Consumer Product tal Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Statistician Safety Commission 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental H Harry Siegel Martha ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i Arthur Present, Husband 5109 Newport Avenue, Bethesda, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cemetery 10/31/06 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Deensee ชื่อใช้ที่เทีย์ใช้ระศัยชิติยพ Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) <u>Cerebral Artery Occlusion with Cerebral Infarction</u> /Medical Due to (or as a consequence of) Examiner Paralysis Agitans if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and as the burial-trail Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)Hospice 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After House (Month, Day Year) within 24 hours aren control to the Funeral Director: Aft 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 30. Name of address of person who completed cause of death (Item 23a) (Type, Print)
Cynthia M. Williams, D.O., 6001 Muncaster Mill Road, Rockville, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

			- FOI	partment of Health and Mental H Prtificate of Death	ygiene 2006 36365
	Physici /Medic	al	Decedent's Name (First, Middle, Last) SARAH J POE	2. Date of D Month OCTOBI	ER 27, 2006 4:12 P M
	Examin Funeral	er	4a. Facility Name (If not institution, give street and number) RAVENWOOD LUTHERAN VILLAGE 5. Social Security Number 6. Sex 1 M 2 S F 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death HAGERSTOWN y) If Under 1 Year If Under 24 Hrs. 8. Date of B (Month, I	ac. County of Death WASHINGTON irth Day, Year) 1,1927 West Virginia
	Director works	J.	Usual Residence of Decedent 10a. State Maryland Washington 10b. City, Town or Hagersto	Location	1,1927 West VIIgIIIIa 10d. Inside City Limits 1 □ Yes 2∑No
	with the Ma a or 28a-f	Directo	10e. Street and Number	10f. Zip Code 21740	10g. Citizen of What Country?
920	i within 72 hours after death with the Maryland liene. r than "naturel", or Items 23a or 28a-f show the Medical Exant art must be indiffed at	by Funeral Director	12.306 Richwood Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:	
21215-0036	d within giene. r than "	Completed	(Specify only highest grade completed) (Gillife Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of working by DO NOT use retired) nomemaker	16b. Kind of Business/Industry her own home
Maryland	should be filed nd Mental Hygi marked other umetic event, I	To Be C	17. Father's Name (First, Middle, Last) George W. Friend	18. Mother's Name (First, Midd Madely	n Blankenship
	nd 2 sh alth and 27 is m r treum		Patricia M. Munch - daughter 142	niling Address (Street and Number or Rural Route Num 54 Exline Road, Hancock, sposition (Name of Date	
Baltimore,	permit. Pages 1 a Department of Hes Importent: if item eny injury or othe		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	awn Memorjal October 31	Hagerstown, Maryland ch Funeral Home
8760,	The law requires that the death certificate be executed	Jicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	enter the mode of dying, such as cardiac or respiratory	Approximate Interval Between Onset and Death 2 Www.
P.O. Box 6	that the death certificated by the attending placed by the action use as the	Physician/Medical		3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	and any my date of great and and any and any and any and any and any any and any any and any any and any any and any any and any and any any and any any and any any and any any and any any and any any and any any and any any and any any any any any any any any any any	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Makhown
Il Records,		Completed	chanz kishing Dinien	24a. Wt aul pei 1 □ Yes	prior to completion of cause of death?
on of Vital	tding Physicien: Th th. : After this certificate funeral director, pag	ition: To Be		e of 28c. Injury at 28d. Describ	y one) sidence 6 □Other (Specify) e how injury occurred
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location City or 1	(Street and Number or Rural Route Number, own, State)
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, di 2 Medicel Exeminer: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s)
)	To I To I	M	29b. Signature and title of certifier	29c. License number D 180(9	29d. Date signed (Month, Day, Year)
ال	√-≲ St Regist	ate	30. Name and address of person who completed cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of death (Item 23a) (Tylindram of the Completed Cause of t	MILL ST HAKERS	70WN MO 21740

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item22 1- State Negistrar WCHD/SH 11/2/06 per FH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Perry 01 2006 Catherine_ Ε. 11 15:05 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M &F Yrs. 98 PA 11/30/1907 Director 165-50-9215 Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or items 23a or 28a-f show 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 TyYes 2 □ No Director Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 20910-4300 8505 Springvale Rd. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: White 3 X Widowed 4 ☐ Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fil timent of Health and Mental H tant: If Item 27 is marked oth Jury or other traumatic even John Castanzo 2 Rose Pingatore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and. Department of Health important: if item 27 any injury or other tr once. Anthony Perry (Son) 788 Case Ave. Johnstown, Pa.15905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Anthony Cem. 11/6/2006 Johnstown, Pa.

22. Name and Address of Facility Frank Duca Funeral Home, Inc.

Frand Duca Funeral Home, St. 21. Signature of Funeral Service Licensee David J. Stretby la. M01035 1622 MenoherBlvd. Johnstown, Pa. 15905 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMENIA MATION disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of Examiner ObsTRUCTION Bowns Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed UKNTRA (UKNTRA) that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. Completed by Physician/Medical phys the L IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 I I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2. No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State
Registrar

DHMH 17 Rev 1/2001

SURRSH

31. Date filed (Month, Day, Year)
NOV 0 2 2006

32. Registrar's Signature

980 GEORGE AVE. #220 Silver Spring, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 206 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** November 11 2006 1149 ELSIE LENORA PREISSLER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center 7. Age (In yrs. last birthday)
Yrs.

| Months | Days | Hours | Min. | 12/10/1917 Bel Air 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 214-18-7408 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Harford White Hall MD. 10e. Street and Number 10g. Citizen of What Country? 2629 Bradenbaugh Road 21161 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be finance and Mental Fig. 18 marked of Fuhrer H. Elsie George Sarah Bond or other traumatic 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21161 Carolyn J. Sciuto/Daughter 2629 Bradenbaugh Rd. White Hall, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite eny Injury or ott 4 ☐ Donation 5 ☐ Other (Specify) St. Mary Cemetery 11/14/06 Pylesville, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardianyopathy Ischemic 1 day Physician /Medical Examiner dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by freumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Tract Infection 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Inflamatory Response Syndrone 1 yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ 16 28c. Injury at Work? 27. Mannes of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕒 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner-stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35012 Nevember 11, 2006

DHMH 17 Rev 1/2001

State

Registrar

00

30. Name and address of per n who completed cause of death (Item 23a) (Type, Print)

6 2006

32. Redistrar's Signature

J. Kevit LYNCH

NOV

31. Date filed (Month, Day, Year)

2 Nerth Ave - Bel Air, Md. 21014

		•	For State Registrar		State	of Ma	aryland /		artmen <i>rtificat</i>			nd M	ental Hy	giene Reg. No		06	36	368
	72		Decedent's Name	(First, Middle	e, Last)								2. Date of De	ath		Year	3. Time of	
_ % F	hysici: Medic/		Louis		Eugene)	Prat	t					Month	12	30		12:1	GAM
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	uneral rector		5. Social Security No. 212-32-7	['] 968	6. Sex 1 M 2 □ I	7. Age	e (In yrs. last 70	birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da Feb 21	h			lace (State o	nr Foreign
land	A TI		Usual Residence of 10a. State	Decedent 10b. County			10c. City, Te	own or Lo	cation							10	0d. Inside Ci	ity Limits
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ith the	or 28	Funeral Director	10e. Street and Num						10f. Zip					10g. Ci	tizen of W		try?	
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yidiliQ Z IZ I 3-0030 buid be filed within 72 hours after death with the Maryland Mental Hygiene.	importent: If item 27 is marked other then "natural", or items 23a or 28e-1 ehow eny injury or other treumatic event, the Medical Examinar must be notified at once.	by Fun	11. Marital Status1 ☐ Never Marrie3 ☐ Widowed		ned 1 7	Forces? s 2 \(\subseteq \) Give or Dates:	No		f Yes, spec	11	Specify:	Puerto F	cify Yes or No Rican, etc.)			, White, e	etc.	
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Daillillo , permit. Pages Department of	importer eny injui once.		21. Signature of Fu			1/	110	. 22				al Ho	me, P.A.					
			23a. Part Enter th	e disease, or	complications th	at caused	I the death. D	o not ente					Cumber respiratory a		, MD 2	1502	Approximat	
Phy	sician		Immediate Cause (i disease or condition	Final	only one cause of	on each lin	he show	he	/	. 1	(Anc	e ₁				Interval Bet onset and I	Death
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centifi	nding use as	n/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes,	outcome	of pregnancy								23d. Date	of delive	ry	
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hat the	d by th		9 ☐ Unknown Part II. Other signifi	cant conditio			ut not resultin	a in the ur	ndorh/ing c	SUCO CINO	n in Part I		23e Did t	obacco	use contrib	oute to th	e cause of d	loath?
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l or Atte	Director I in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could a	ined 286. PI	ace of Inju	ury - At home c. (Specify)	, farm, stre	eet, factor	, office		2	8f. Location (S City of Tox			r or Rural	Route Num	ber,
To the Hospitel or Attending within 24 hours after death.	To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)	1 Cartifyin	ig Physician: To Examinar: On th	the best of	examination	dge, death and/or in:	n occurred vestigation	at the tim , in my op	e, date and inion, deat	place, a	nd due to the	cause(s date an	and man d place, ar	ner as stand due to	ated. the cause(s	i)
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	10		30. Name and addre	ess of person	who completed o	ause of de	eath (Item 23					- 1						U YO
1000	Sta	to	Gary W	agone	r M.D.	2. Redistra	ar's Signature	925 E	Bishor	Wa	lsh Dr	ive (Cumber	land	IMD.	2150	2	
	ات Registr			NOV I	6 2006	TEN.	ar's Signature	J. 1	Spark!	E B								

			1 - For State Registrar	State of Marylar	nd / Depa	artment of I rtificate of	Health and Death		Reg. No.	
ı	Physici /Medio		1. Decedent's Name (First, Middle, Last) JULIA ETHEL THO					2. Date of De.	ath 30 ^{Day} 2006 ^{ea}	3. Time of Death
	Examir		4a. Facility Name (If not institution, give s BRINTON WOODS I	HEALTH CARE			SVILLE		4c. County of De	L
	Funeral Director		5. Social Security Number 215-54-9934 Usual Residence of Decedent	7. Age (In yrs. M 2MF 81	last birthday) Yrs.	If Under 1 Year Months Days		in. 8. Date of Biri (Month, Da DEC 30	9. B by, Year) 1924	irthplace (State or Foreign Country) VA
	a-f ehow	ctor	10a. State 10b. County MONTGON		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28	I Dire	10e. Street and Number 9128 GUE ROAD			10f. Zip Code 20872			10g. Citizen of What (Country?
5-0036	should be filed within 72 hours after deeth with the Maryland of Menial Hygiene. marked other than "natural", or iteme 23e or 28e-f ehow matic event, its Madical Essential marke nutified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	14. Race - Ar Black, Wi Specify: W	
21215-0	a within 72 ho piene. r than "natur itte Madical!	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) unknown	cation a completed) Cotlege (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of v d)	working	16b. Kind of Busines	·
Baltimore, Maryland 2121	should be filed ind Mental Hygie marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) RICHARD W. THOM	MAS				lame (First, Middle, WRIGHT	Maiden Sumame)	
Mar	s 1 and 2 should f Health and Men item 27 is marke other treumatic	·	19a. Informant's Name/Relationship (Type GEORGE POOLE /	ре, Print) SON	1			Rural Route Number	er, City or Town, State	_ '
more,	Pages 1 e nent of Hec int: if item iry or othe		20a. Met/lod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery, crea	osition (Name of matory or other pla RESBYTE		Date / 2 / 0 6	20c. Location - City of BOYDS,	
Baiti	permit. Pages Department of I Important: If its eny injury or o		21. Signature of Funeral Service License	99		2. Name and Addre	FUNERA.	L HOME	LLE, MD	20838
	Certificate be executed with the principle of the princip	dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line. PRIMARY DE Due to (or as a consec	h. Do not ent EGENEF uence of):	ter the mode of dy	ng, such as card	liac or respiratory as		Approximate Interval Between Onset and Death 1 year +
.O.	death e atter	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/sths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of degree Unknown	Ideath 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у		23d. Date of d Month	elivery Day Year
<u> </u>	The law requires that the one by the bas been signed by the bage 2 should be detache	ρ	Part II. Other significant conditions con		ulting in the u	inderlying cause gi	ven in Part I.		obacco use contribute Yes 2 No 3	to the cause of death? Probably 4 Munknown
l Records,		Completed	ISCHEMIC HEAR	T DISEASE						
Vita	sician: The second continue to a	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	ot all pos Oth		Death (Check only o	one) dence 6 □Other (Sp	
Division of	Attending Physician: or death, ector: After this certifically the funeral director,	⊢	27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju Wo			how injury occurred	несту)
DIVIS	_ @	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, sti y)	reet, factory, office		28f. Location (S City or Tox	Street and Number or wn, State)	Rural Route Number.
	To the Hospital o within 24 hours aft To the Funeral Di completely filled in	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	sician: To the best of my knowner: On the basis of examinating manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	me, date and pla opinion, death o	ace, and due to the courred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the To the Comp	W	29b. Signature and the of certifier			29c. Licens	ofuc		29d. Date signed/(Mo	nth, Day, Year)
	9		30. Name a. Vaddress of person who co	s Suite 10	2. 10	Print) LiBox	22420	ELDORSH	10/30/06 BULD, UD	
	Sta Registr		31. Date filed (Month Oey, Year) 20	06 32. Jegistrar's Signa	B. A	acres .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 30, 2006 ear **Physician** 9:45 Рм LaRue Foxwell Pover /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 2/16/1932 1 □ M 2 🔀 F Maryland 74 218 28 2003 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Woodbine Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 15501 Frederick Rd. 21797 Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Alfred Foxwell Helen Decker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15501 Frederick Rd. Woodbine, MD 21797 19a. Informant's Name/Relationship (Type. Print) Woodbine, MD 15501 Frederick Rd. Charles Poyer / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If it
any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 10/31/2006 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) M01442 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pk. Ellicott City, MD 21043 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final reast CANCER ean Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Entar Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending after death.

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ral", or items 23a or 28a-f show Examiner must be notified at

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Health item 27

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attending physician

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use

page 2

funeral director

the

Medical

29a. Certifier

After

Pages 1 iment of Hi

other traumatic event, the Medical

and 2 should be filed within fealth and Mental Hygiene.

To the Hospital or Atte within 24 hours after de:

To the Funeral Directo completely filled in by the

State Registrar

3 1

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) October 31, 2006

iles St. Balto Md 2120x

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print) 6701

2006

strar's Signature

Grant

	•	For State Registrar	State of Maryland /	Department of Hea	eath	Reg. I	2006	3637
Physicia /Medic	al .	_	ret Pritchett	4b. City, Town, or Lo	C)CTOBER	28 200 4c. County of Deat	
Examine Funeral Director	er	4a-Eacility Name (If not institution, give DOR CHEST 5. Social Security Number 6. Se 218-20-5472	ER GENERALHO	SPITAL An	OBRIDO f Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Yea Sept. 13,1	DOR 9. Birt Co	CNESTE hplace (State or Foreigntry) ryland
Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Dorchest	10c. City, To	wn or Location oridge				10d. Inside City Lim 1 ☐ Yes 2X
with the	Direc	10e. Street and Number 106 Richardson Dri		10f. Zip Code 21613		10g.	Citizen of What Co	puntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature!", or items 23s or 28s-f show my injury or other treumatic event, the Medical Examinar must be notified at 20cs.	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates:	13. Was Decedent of Hisp. If Yes, specify Cuban,		ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
vithin 72 hound. ne. han *nature	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		a. Decedent's Usual Occupatio (Give kind of work done dur- life. DO NOT use retired)	on ing most of working	7 16b	. Kind of Business	
z should be filed within and Mental Hygiene. ie marked other than eumatic event, the Market	To Be Co	17. Father's Name (First, Middle, Last) Oscar P. Lyons		Homemaker 18	8. Mother's Name (First, Middle, Maid	OWN HON	ne
nd 2 should th and Mer 27 ie marke r treumatic		19a. Informant's Name/Relationship (7) Buddy Pritchett	ype, Print) 19	9b. Mailing Address (Street and				
ages I and a nt of Health a t: if item 27 i		20a. Method of Disposition XXBurial 2 Cremation 3	Removal from State	of Disposition (Name of tery, crematory or other place)	Da	te 20c	. Location - City or	
permit. P Departme Importen any Injury once.		4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens	/	22. Name and Address Thomas Fune 700 Locust				
Medical Examiner private priva	cal Examiner	23a. Part Enter the disease, or comp shock, or heart failure. List only of the class of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	e of):				Approximate Interval Between Onset and Death
Attanding Physician: The law requires that the death certificate be excreasing. rdeath. sctor: After this certificate hes been signed by the ettending physicien by the funeral director, page 2 should be detached for use as the buria	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnancy 5 Other (specify)			23d. Date of de Month	livery Day Year
uires thet signed by Id be deta	d by Pr	Part II. Other significant conditions co	ontnbuting to death but not resulting	in the underlying cause given	in Part I.	23e. Did tobace		o the cause of death? robably 4 ©Unkno
The law require	Complete					24a. Was an autopsy performed	prior to death?	utopsy findings availa completion of cause s 2/3 No
ysician: Th is certificete director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 MER/	Outpatient 3 DOA Other:	26. Place of Death		e 6 ☐Other (Spe	ecify)
를 들는 다	Certification: T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Natural 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year)	o. Time of lnjury a Work? M 1 □ Ye	it 2	8d. Describe how i	njury occurred	ural Route Number,
Hospital 24 hours a Funeral listely filled	Medical C		ysician: To the best of my knowled liner: On the basis of examination and manner stated.					
To the within 2 To the comple	Me	29b. Signature and title of certifier	to MD.		64147		Date signed (Moni	
		30. Name and address of person who of i2OSA MA NOO 3 31. Date filed (Month, Day, Year)		CAMBRIDGE	E MO	21613		

06-08588 Agnes Ann Parsons

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

grie	es Am	1 213	1	State Of Maryland A	Certifica			a Mente		eg. No 201	16 3637
ē,		sicia	ın/	Decedent's Name (First, Middle,Last)					Date of Deal Month		3. Time of Death 1520 hrs
/lec	dical Ex	camii		Agnes Ann Parsons 4a. Facility Name (if not institution, give street and number)			. City, Town, or	Location of I	Month November	r 11, 2006 4c. County of De	
				12108 Blue Bell Avenue		146	Cumberland		Death	Allegany	sau i
	Fun	eral		5. Social Security Number 6. Sex 7. Agr	e (In yrs. last birt	hday)	If Under 1 Yea	r If Under 2	24Hrs. 8. Date of Bir		
	Dire		L	212-94-9185 1 M 2 X F Usual Residence of Decedent	43	Yrs.	Months Day	s Hours	Min. Aug 21		reign Country) MD
		any	-	10a. State 10b. County	10c. City, Town	or Locatio	n			-	10d. Inside City Limits
	and	28a-f show any 1 at once.	ъ	MD Allegany	Cumbe	rland					1 X Yes 2 No
	Maryl	dat o	Director	10e Street and Number			10f, Zip Code			0g. Citizen of What C	Country?
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-	ath wi	items ist be	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Armed Forces?	,				? (Specify Yes or No uerto Rican, etc)	White, etc	nerican Indian, Black, c.
	fter de	r, or		1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year or Pates	X No	1	Yes 2 X No	specify:		Specify: W	hite
m	ours a	atura	d by	15. Decedent's Education (Specify only highest grade con	npleted) 16a.		s Usual Occupat		nd of work done	16b. Kind of Busine	ss/Industry
	36 n 72 h	than "natu edical Exan	Completed	Elementary/Secondary (0-12) College (1-4 or s	5+)					Pooley Co	n Poport
	-0036 within giene	other than the Medical	E O	12 17. Father's Name (First, Middle, Last)	по	stes		18.Mother's	Name (First, Middle, I	Rocky Ga Maiden Surname)	p Resort
	21215-0036 muld be filed within 7 Mental Hygiene	ked of	Be C	John J. Frick, III				Josep	hine (Snyd	ler) Frick	
	21 rould b	is mar		19a. Informant's Name/Relationship (Type, Print)					er or Rural Route Nur		tate, Zip Code)
	e, MD 21215-00 I and 2 should be filed with Health and Mental Hygien	rm 27	-	Josephine Frickmother 20a. Method of Disposition			ion (Name of ce		Vale, MD	21502 20c. Location - City	or Town State
	Baltimore,	tant: If item 27 is n or other traumatic		1 XBurial 2 Cremation 3 Removal from St.	ate cremat	ory or othe	er place)	•	11/16/2006		
	Baltimore permit. Pages I Department of H	y or o	-	4 Donation 5 Other Specify: 21/\$ignature of Fyineral Service Licensee	St. A		se Cemet		al Home, F	1	Own, FID
	Ba perm Depa	Injury Tugur	1	Hicholas & Sono	rdVi-				e; Cumberl		21502
	Physic		\exists	23a Part I. Enter the disease, or amplications that caused failure. List only one cause in each line	the death. Do no	ot enter the	mode of dying,	such as car	diac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
	/Med	_		Immediate Cause (Final disease a. Di henhydr		oxicat	ion				Death
				or condition resulting in death) Due to (or as a conse	equence of):						
			je	if any, leading to immediate Due to (or as a const	equence of):						
			Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a constitution of the constitut	equence of):						
	anted	nd ransit	1	dd							
	, se exec	physician and the burial - transit	Medical	X UNPENDED AMENDED #23	3a,27,28a-	f. per	ME. 2862.	12/21/	/06 TT		
	Box 68760, e death certificate be	physi the bu		IF FEMALE: 23c. If yes, outcome 23c. If yes, outcom	me of pregnancy					23d. Date of deli Month	very Day Year
	x 68	attending or use as	ciar	past 12 months?	Character and a state		al death 3 er (Specify)		pregnancy	WOTE	Day Teat
	Bo) e death	41	Physician	1 Yes 2 No 9 V Unknown 9 Unknown							
•	P.O.	ned by the detached	b P	Part II. Other significant conditions contributing to deat	h but not resultin	ig in the ur	iderlying cause	given in Part			e to the cause of death? Probably 4 Unknown
	ds, L	s been sign should be	Completed						24a Was	an 24b. Were	e autopsy findings available
	COF	ha 2	nple.							rmed? death	
	.:	certificate ector, page		25 Was case referred to medical			26.Place	e of Death (C	1 Yes	2 No 1	Yes 2 No
	Vita	his cer directo	o Be	examiner?	ent 2 ER/O	utpatient	3 DOA	Other _	Nursing Home 5	Residence 6 🗸 0	ther: Scene
	of of Briggs Phy	After the	-	27. Manner of Death 28a. Date of Inj. (Month, Day,)		Time of In		iry at Work?	1	how injury occurred	
	ion ttendi	tor: /	atio	Natural 5 Pending Fnd 11/11		d 3:00) Dill	Yes 2 X N	Subject	ingested pi	
	Division of Vital Records, tal or Attending Physician: The law requirers after death	I Direct	Certification:	Suicide Could not be determined (Specific)	njury - At home, f	arm, stree	, factory, office I	ouilding, etc.	or Town, S	State) 12108]	r Rural Route Number, City Blue Bell Ave.
•	lospita Phours	fill.		4 Homicide 29a Certifier A Continue Physician To the best of m	House	ath occurr	ed at the time d	ate and plac	Cumberla e and due to the caus		started
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	To the Fu	Medical	one) 2 Medical Examiner: On the basis of examiner stated.	mination and/or	investigati	on, in my opinior	n, death occu	urred at the time, date	and place, and due t	o the cause(s)
-	— ₹	F 3	Me	29b. Signature and title of certifier			29c Licens			29d Date signed	
				Wrynte The Soul	(O.C.	M.E.		November 12	, 2006
				30. Name and address of person who completed cause of Margarita Korell MD. Assistant Medical		111 Pa	enn Street, E	Saltimore	MD 21201		
			tate	31 Date filed (Montal Day/Year) 5 7006 32 Registra	ar's Signature		officer, E				
	F	اد egis		1101 1 3 2000	1000 50	DE TON	All and the second				

Physicia	an_	1 - For State Registra MEND#10bperFF 1. Decedent's Name (First, Middle, Li	ast)		ificate of L		2. Date of De.	Reg. No Z	Year	36373 3. Time of Death
/Medic	al	CATHERINE 4a. Facility Name (If not institution, gi	ROMAS ve street and number)		4b. City, Town, or	Location of Dea	OCTOBE		2006 ounty of Death	11:35A M
Funeral Director			1d Sex 7. Age (<i>In yr</i> s 1 □ M 2	. last birthday) Yrs.	College If Under 1 Year Months Days	Park If Under 24 Hrs Hours Mir		th y, Year)	Coun	ace (State or Foreign
Aarylend f ehow	ō	10a. State 10b. County Prince C	George's	ity, Town or Loca					1	0d. Inside City Limits
or 28a-	Directo	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Coun	try?
I within 72 hours after death with the Marylend ilen. Ithen "natural", or iteme 23a or 28a-f ehow the Maulical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1		20740 as Decedent of His Yes, specify Cubar Yes 2 XNo		Specify Yes or No rto Rican, etc.)		Race - Americ Black, White, pecify: White	etc.
hin 72 hou In "natura Medical E	Completed	15. Decedent's E (Specify only highest gi	Education	(Give ki	nt's Usual Occupa ind of work done d O NOT use retired)	uring most of we	orking	16b. Kind	of Business/Ind	lustry
filed within Hygiene. other then " ent, the Mes	e Com	12 17. Father's Name (First, Middle, Las	4	· ·	Marketin		ame (First, Middle,		mama)	ractor
S d in o	To Be	Anthony Peter Ro					ia Camesa			
0 4 4 5		19a. Informant's Name/Relationship Anthony Peter Ro					Rural Route Numbe			
permit—dages 1 and Department of Health Important: If Item 27 any injury or other to		20a. Method of Disposition 1	☐Removal from State	ate of H	eaven Cen Name and Address	metery s of Facility H	ines Rina	Silve aldi F	uneral	ng,Marylan
Medical Examiner bhysicien and sthe burial-transit	dical Examiner	disease-econdition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hepatic Fai Due to (or as a conse b. Metastatic Due to (or as a conse c. Due to (or as a conse d.	quence of): Saliver quence of):	y Cancer					1 week 7 years
ath certif ttending or use a:	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3⊟E	ctopic pregnancy Other (specify)			23d	. Date of delive Month	ry Day Year
luires that the de signed by the a lid be detached f	þ	Part II. Dther significant conditions	contributing to death but not re	sulting in the und	erlying cause give	n in Part I.				e cause of death?
The law ate has t page 2 s	Completed							an 2 ssy rmed? 25 No	prior to con death?	sy findings available appletion of cause of 2 No
Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2] ER/Outpatient	3 DOA Other	-	ath <i>(Check only o</i> Home 5 X Resid		Other (Specify	1
To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,	Certification; To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 Y		28d. Describe h	now injury of	curred	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Cert	29a. Certifier 1 Tecertifying P	hysician: To the best of my kn miner: On the basis of examin	owledge, death o	occurred at the time	e, date and plac	e, and due to the curred at the time.	cause(s) and	d manner as st	ated.
To the P within 24 To the F complete	Medi	29b. Signature and Me of certifier	J Celler	- MI	29c. License	number		29d. Date si	gned (Month, L	Day, Year)
	1	30. Name and address of person who			int)		aryland	2120		

			for State	State of Ma	arylan			nt of H e <i>te of L</i>		d Men				
(4)	N.	_ 5	Registrar 1. Decedent's Name (First, Middle, La	st)		001	unca	10 07 2	Jean		Date of Deatl	g. No.	2006	3. Time of Batt
	Physici /Medic		Kaywal Krishn	adath Ramkiss	oon						Month ctober	Day 26,	Year 2006	8:59 p ^M
٠ د	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. Cit	y, Town, or	Location of D	eath		4c. 0	County of Death	
			Washington Advent		/In ura	ast birthday)	If I Ind	Tal er 1 Year	koma Par		Date of Birth]]	Montgomer	
	Funeral Director			M 2□F	63	Yrs.	Month			Vin.	Month, Day, gust 28		Cour	place (State or Foreign htry) dad, W.I.
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation						1	0d. Inside City Limits
	Aaryla f shored ed at	o			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, ,		. 1	C					1 □Yes 2 ☑ No
	the l	Director	Maryland Montgome: 10e. Street and Number	У			_	ip Code	Spring		10	g. Citiz	en of What Cour	ntry?
	h with		15332 Aylesbury	Street					20905				U.S.A.	
	ems ?	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.	S. 13. \	Nas Dec	edent of Hi	ispanic Origin' an, Mexican, P	? (Specify Puerto Rica	Yes or No- n, etc.)	1	4. Race - Americ Black, White,	
36	be filed within 72 hours after death with the Maryland that Hyglene. Ad other than "natural", or tlems 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	lo			2 X No	Specify:				Specify: Ind:	
5-003	2 hour	ed k	15. Decedent's E	ducation	- 1	16a. Deced	dent's Us	ual Occup	ation			l6b. Kin	d of Business/In	
212	hin 7%	Completed	(Specify only highest grade) Elementary/Secondary (0-12)	ade completed) College (1-4or 5-	+)	(Give life. I	kind of v DO NOT	ork done d use retired	during most of ()	working	T.			
_	filed wit Hygien other tha	Con		5+	,	Graph	ic De	esigne					ducation	
Maryland 2	be fill ad oth even	Be	17. Father's Name (First, Middle, Last						18. Mother's	,			Surname)	
Ĕ	nd 2 should be th and Mental 27 Is marked o traumatic eve	은	Latchmidath I	**		19b. Mailir	a Addre	ss (Street :			amkisso ute Number		Town, State, Zip	(Code)
<u> </u>	0.00		Radhica K. Ramkissoo				-	,				-	Maryland 2	,
Jre,	- I & =		20a. Method of Disposition	•	20b. P	ace of Dispo				Date			ation - City or To	
Ĕ	Pages ment of l ant: If Its ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.		Fort	Lincol	n Cre	ematory	y 1.	1/1/20	06	Brent	twood, Mar	yland
Baltimore,	permit. Page Department Important: Il any Injury o		21. Signature of Funeral Service Lice	nsve	+	H	lines:	Rinalo	ss of Facility	al Hom	e			
	40260		23a Parti Enter the disease or com	unlications that caused	the death								oring, Mar	yland 20904 Approximate
	Discontinuo	e ni	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate (Fina)	one cause on each lin					g, such as car	Idiac of fee	phatory arre	ist,		Interval Between Onset and Death
-	Physician / /Medical		disease condition resulting in death)	a. ACU Due to (or as a		erucy ience of):	eax	1 40	01					3 days
	Examiner		Sequentially list conditions	b										
	be sit	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a	a consequ	ence of):							3	
	xecut and	Examine	that initiated events resulting in death) Last	c Due to (or as a	a consequ	ence of):								
09/89	ificate be executed g physician and as the burial-transit	edical E	l (_ d										
_	rtificat ng phy as th	ledi												
gog	leath certifi attending I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome page 1 ☐ Live birth	2 Fetal	death 3	Ectopic	pregnancy				23	3d. Date of delive	ery Day Year
0	The law requires that the death cert te has been signed by the attending age 2 should be detached for use	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of de	eath 5□	Other (specify)					WOTH	Day
٦.	res that the signed by be detaction		Part II. Other significant conditions	contributing to death bu	it not resu	lting in the u	nderlying	cause give	en in Part I.		23e. Did tob	acco us	e contribute to ti	ne cause of death?
Vital Hecords,	quires n sign ald be	d by	Coronary ar	tery dis	eas	e .				_ //	1 ☐ Ye	s 2	No 3□ Prot	pably 4 Unknown
င္ပ	aw require s been sig 2 should t	Completed	0								24a. Was an		24b. Were auto	psy findings available
Ĭ	sician: The law certificate has l irector, page 2 s	mo								_	autopsy perform 1□ Yes 2	1ed2	death?	mpletion of cause of 2 ☐ No
Ig	ctor, I	Be C	25. Was case referred to medical examiner?						26. Place of					
	Physlo this or al dire	은	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie		ER/Outpatien			4 LI Nursir				☐Other (Specif	y)
ב	ding F	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injur (Month, Day		28b. Time of Injury	M	28c. Injun Work	yat <br Yes 2∐No	1	Describe ho	w injury	occurred	
DIVISION OF	or Attendated after death Director:	fical	3 Suicide 6 Could not b	e 28e. Place of inju	ıry - At ho	me, farm, str				28f. t	ocation (Str	eet and	Number or Rura	al Route Number,
É	pital or ours after leral Direction the filled in the	Certification:	4 ☐ Homicide determined	building, etc	:. (Ѕреспу	")				(City or Town,	, State)		
	e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certific itetely filled in by the funeral director,	Medical (29a. Certifier 1 ✓ CertifyIng Pl (Check only one) 2 ☐ Medical Exa	nysician: To the best of miner: On the basis of	examinat	vledge, death ion and/or in	occurre vestigation	d at the tin	ne, date and p pinion, death o	olace, and o	due to the ca t the time, da	use(s) a ate and	and manner as s place, and due to	tated. o the cause(s)
	To the Hos within 24 ho To the Fund completely f	Med	29b. Signature and title of certifier	and manner sta			2	9c. License	e number		29	d. Date	signed (Month,	Dav. Year)
			Fromy P. Kan	naskat	, /	no		D2	0063	2		oct	77,	2006
			20 Name and address of nerson who	completed cause of de	ath (Item	23a) (Type,	Print)							
			TONY P. KANNAH				"st	. 51	LVER	SPRI	NG. 1	MA	RYLAND	0 20910
	Sta	te	31. Date filed (Month, Day, Year)	Mh 37 Nègistra	ır's Signa	ture	MES.							

			1 - For State Registrar	State of	Marylan	_	artment o			d Mental Hy	giene)6	36375
	Physic /Medi		1. Decedent's Name (First, Midd Joe Frede)		р					2. Date of De. Oct. 31		Year	3. Time of Death 4:05am
4	Exami		4a. Facility Name (If not institution 13628 Blain	svalley	Road		4b. City, Tor Clear	Sp	ring	,	4c. County Wash	ing	
	Funeral Director		5. Social Security Number 218-30-9401 Usual Residence of Decedent	6. Sex 7 ½ □M 2□F	. Age (In yrs. 7 1	last birthday) Yrs.	If Under 1 \ Months D			in. June .	3,1935	9. Birth	place (State or Foreign ntry)
	Maryland a-f show	tor	10a. State 10b. County	ington		y,TownorLo		,					10d. Inside City Limits 1 ☐ Yes 2 ▼No
	th with the 23e or 28a	al Direc	10e. Street and Number 13628 Blair	svalley F	₹đ.		10f. Zip Co	722			10g. Citizen of W		ntry?
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. It will be seen at 18 marked other than "natural", or Iteme 23e or 28e-f show other traumatic event, the Medical Exeminant be routified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 □ Divorceo	If Yes Give	es? ! ∑ No	'	Was Decedent f Yes, specify		nic Origin? exican, Pu pecify:	(Specify Yes or No- erto Rican, etc.)		e - Americ k, White, white	
Maryland 21215-0036	ed within 72 h yglane. ner than "natu t, Ire Medical	Completed	(Specify only higher Elementary/Secondary (0-12) 10th grade	nt's Education st grade completed) College (1-2	For 5+)	(Give	lent's Usual C kind of work of DO NDT use r Ck La	lone during etired)	g most of v	vorking	16b. Kind of Bu Mason		*
/land	uld be fil Mental H Irked oth	To Be	17. Father's Name (First, Middle, George Dav							lame <i>(First, Middl</i> e, 1 Blanc			
Man	alth and I		19a. Informant's Name/Relations Ellen A. R		e					Rural Route Numbe			
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr pnce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5	3 □Removal from St	ate B1	lace of Dispo emetery, cren airsv	sition (Name on atory or other	of r place)	No	V 4 .	20c. Location - Clear S	City or To	own, State
Balti	permit. Pages. Department of H Important: If ite any injury or of		21. Signature of Turieral Service	1 fants	4 6	D 222	Name and A	ddress of Edw	Facility in T	hompson	Funera	1 H	ome
	Physician /Medical Examiner		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	as a consequ	anc				ac or respiratory and	. 1025		Approximate Interval Between Onset and Death
8760,	vate be executed obysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequ								
.O. Box 6	death certific e attending p id for use as	Physician/Med	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Fetal it at time of de	death 3	Ectopic pregn Other (specif				23d. Date Mon		ery Day Year
rds, P	equires that en signed outd be de	by	Part II. Other significant conditi	ons contributing to deal	th but not resu	ulting in the un	derlying cause	e given in i	Part I.				ne cause of death? ably 4 □Unknown
	The law ate has b page 2 sl	Completed								24a. Was a autops perform	pred? de	rior to con eath?	psy findings available inpletion of cause of
of Vital	Physiclen: 'this certifica	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 No	Hospital: 1 Inp	-	ER/Outpatient		Other: 4		eath <i>(Check only or</i> Home 5 A Peside		r (Specify	7)
	ding 7. After fune	atlon	27. Manner of Death 1 Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	injury Day Year)	28b. Time of Injury		Injury at Work? 1 Yes	2 🗆 No	28d. Describe ho	ow injury occurre	d	
Division	in Signal	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Place of	Injury - At ho , etc. (Specify	me, farm, stre	et, factory, off	fice		28f. Location (Si City or Town		r or Rural	Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	one)	g Physicien: To the be Examiner: On the basi and manner	s of examinat	wledge, death ion and/or inv	occurred at the	ne time, da ny opinion	ite and place, death oc	ce, and due to the courred at the time, d	ause(s) and man ate and place, ar	ner as stand due to	ated. the cause(s)
)	To To COT	M	29b. Signature and title of certifie	7alina	~	MI	29c. Lic	cense num	iber oろうし	33	9d. Date signed	1	Day, Year)
51	1-4		30. Name od a dress o erson	o completed cause	of death (Item	23a) (Type, F	rint)	St	الديد	mo	2121	75	Ü
	Sta Registr	. 100	31. Date filed (Month, Day Year)	1 2006 32. Res	istrar's Signat	ure A. A	neste			1		1	

			For State of Maryland / [- State Registrar	Department of Health and Certificate of Death		iene2006	36376
	*		Decedent's Name (First, Middle, Last)		2. Date of Deatl	h	3. Time of Death
	Physicia /Medic		Leonard Stanley Rebarchick		October	30, 2006	5:15 A M
p	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death	
			Charlotte Hall Veterans Home	Charlotte Ha		St. Mary	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs Months Days Hours Min	. (Month, Day,		lace (State or Foreign
	Director	}	171-01-1742 'A 90	113.	September	2 3 1916 Hazel	ton, PA
	/land		10a. State 10b. County 10c. City, Tow	n or Location		1	0d. Inside City Limits
	Man a-f sh	ģ	Maryland St. Mary's Holly	wood			1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	itry?
	death with the Maryland me 23a or 28a-f show	rai	45100 Nolan Court	20636		USA	
	teme	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puel	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
9	hours after tural', or its	by F	1 □ Never Married 2 □ Married 1 ♣ Û Yes 2 □ No If Yes, Give 1943-1946 Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Whi	te
2-003e	o 72 hours after death with the Marylan "neturel", or Iteme 23a or 28a-1 show adical Examiner man be milliad at			Decedent's Usual Occupation	-	16b, Kind of Business/Inc	dustry
2 2	nin 72 in "nat	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired)			
7	d within giene. er then "	Completed	8	Owner		Restaurant	
B	be filed stal Hygid of other event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, M	Maiden Surname)	
<u>X</u>	·	2	Frank Rebarchick		ca Vidins		
Maryiand	l 2 sh I and I em			Mailing Address (Street and Number or R	·		Code)
	ss 1 and 2 should of Health and Me frem 27 le mark r other treumation	. 8	20a Method of Disposition 20b, Place o	5100 Nolan Court, H		20c. Location - City or To	wn. State
altimore,	permit. Pages Depertment of I Important: If Ite eny Injury or of		1X Burial 2 ☐ Cremation 3 ☐ Removal from State	ry, crematory or other place) Nove	ember 2,	exington Park	
	ortme ortme ortani injury		4 □ Donation 5 □ Other (Specify) Immacul 1:	ate Heart of Mary 22. Name and Address of Facility	2006		
ä	Dep mb eny eny		Bichook Spordines	Mattingley-Gardiner Ft 41590 Fenwick Street,	ıneral Home, Leonardtown	, P.A. n, MD 20650	
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		· · · · · · · · · · · · · · · · · · ·	strointegtinal	Bleedi	ina	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence	of):	10100	1	
Н	Examiner		Sequentially list conditions, b. Mpey le	m Sion			
	bed isit	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
ь.	xecut and al-trar	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence	of):			
28760	ficate be executed physicien and is the burial-transit	alE	Coronary	disorde Arteny di	sease		
89	g phy as the	edical					
ŏ	death certifica e attending pl d for use as t	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of delive	
B	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death	5 Other (specify)		Month	Day Year
о. О	law requires that the de as been signed by the a 2 should be detached t	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part I	23e Did tob	acco use contribute to the	na cause of death?
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	ysicien: is certific director.	To Be	examiner?	Other		ince 6 Other (Specifi	y)
פר	ding Ph h. After th funeral			Time of 28c. Injury at Injury Work?	28d. Describe ho	w injury occurred	·
<u>0</u>	ttendir death. ctor: Af y the fu	atic	2 Accident investigation	M 1 Yes 2 No			
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	pitel ours a erel [29a. Certifier Certifying Physicien: To the best of my knowledge	e death occurred at the time, date and place	e and due to the ca	useds) and manner as si	atad
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination ar and manner stated.				
	To the To the Comple	Me	29b. Signature title of certifier	29c. License number	29	9d. Date signed (Month,	Day, Year)
	•		hand Atman	D4509-	3	10/31/0	7
(DC		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	_	- 1 1 := 1	20100
	4		10 trespital Koad Su	ue 200 Pri	nce 17	red neu	- cook
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 1 2006 32. Pegistrar's Signature	Lord's			
100	- 220	555	TOTAL TOTAL	The same of the sa			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 3637 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25 2006 **Physician** October 2325 Dorothy I. Robinson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical **Annapolis** Center If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Aug 23 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2X F 1913 93 Yrs. Director 126-20-6591 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1√2 Yes 2 □ No Annapolis Director Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 USA 1949 Drew St. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify Specify: Black Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker None 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Kimball James Queen ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George W. Belt(Son) 1949 Drew St. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veteran 10-31-06 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. Lavy B. Reese MOO 483 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 NO 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2□ No 1 ☐ Yes Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) . 24 hou₁.c the Funeral Direc. ∵¹v filled in b≀ 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 24 29c. License number 29d. Date signed (Months Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint)

32. Registrar's Signature

00

31. Date filed (Month, Day, Year)

10

26

		State of Maryland / Deprint State Amend #12,16a, perFH, Inf, G861, 11/30/2	artment of Health and M Rifficate of Death	ental Hygien	Z U U b . 3 b 3 / b
		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Physic /Med		Leonard J. Riccio		Nov. 04	2:30 p M
Exami		4a. Facility Name (If not institution, give street and number) 6770 Eldorado Road	4b. City, Town, or Location of Death Federalsburg		lc. County of Death Dorchester
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, $169-14-4540$	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Oct. 25. 1	9. Birthplace (State or Foreign Country) 1921 Pennsylvania
P.		Usual Residence of Decedent			
arylar show	2	10a. State 10b. County 10c. City, Town or U MD Dorchester Federa			10d. Inside City Limits 1 ☐ Yes 2√☐ No
the M	Director	MD Dorchester Federa	10f, Zip Code	100.0	Citizen of What Country?
with with	ā	6770 Eldorado Road	21632		ited States
death ms 23	Funeral		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
lar y idilia Z 1 Z 1 Z 1 Z 2 Z 2 Z 2 Z 2 Z 2 Z 2 Z 2	by Fur	Armed Forces? 1 Never Married 2 Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 3 No 41-71 If Yes, Give Year or Dates: 45 70	1 ☐ Yes 2 ½ No Specify:	Hican, etc.)	Black, White, etc. Specify: White
2 hou		(Case it and highest grade completed)	edent's Usual Occupation a kind of work done during most of worki	0.0	Kind of Business/Industry
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ed wi	ြင်	2 0.3.	Naval Officier	OLLICEL	ilitary
be fill	Be	17. Father's Name (First, Middle, Last) John Leonard Riccio	Lucy D	(<i>First, Middle, Maide</i> ePa1ma	an Surname)
hould d Mer mark mark	10		ing Address (Street and Number or Rura		v or Town State Zin Code)
d 2 s d 2 s th an t7 le r		,	= '		sburg, MD 21632
the Heel		20a Method of Disposition 20b. Place of Disp			Location - City or Town, State
Peges entol nt: if i		1 □X8urial 2 □ Cremation 3 □ Removal from State Eastern 3	Sh. Vet. Cem.11/08	3/06 Hu	ırlock, Maryland
paritificate, interpretation A 12 10-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Heelith and Mental Hygiane. Important: if item 27 is marked other than "naturel", or Items 23s or 28s-1 show eny Injury or other traumatic event, the hydical Examinan must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of FacilityFra 16 N. Main St., Fe	mptom Fu	neral Home, P.A.
certificate be executed certificate be executed by executed certificate be executed by exec	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Sarcoma,	or respiratory arrest,	Approximate Interval Between Onset and Death Cembrith S
oo / ou ificate be e g physicien as the buri	edical	d			
death death	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Ords, F.C requires that the een signed by th hould be detache	_ ≥	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death? 2 LNo 3 Probably 4 Unknown
Q & 8 C	Completed			24a. Was an autopsy performed	
VITAL H sicien: The certificete h rector. page	0	25. Was case referred to medical	26. Place of Deat	1 ☐ Yes 2 ☑ 1 (Check only one)	No 1 ☐ Yes 2 ☐ No
OT VI Physicia this cer al direct	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other		6 ☐Other (Specify)
On Of oding Phy th. : After this stuneral d		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		28d. Describe how in	njury occurred
DIVISION OT VITA Hospital or Attending Physicien: 44 hours effer death. Funeral Director: Affer this certific tely filled in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28t. Location (Street City or Town, St	and Number or Rural Route Number, ate)
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To the I within 2: To the I complet	N	29b. Signalore and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Typ.	D / (0)	/	1/6/08
		Dr. David Smith, 29466 Pintal	1 Dr. 45 Easton	, md. 216	,01
S Regi	State strar	31. Date filed (Month, Day, Year) NOV = 8 2006 32. Refistrar's Signature	breiter		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® O O C

		1	For State Registrar	state of Marylar	na / Depa <i>Cer</i>	artment of H rtificate of l	eaith and M D <i>eath</i>		ene 006	36379
	Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al -	MICHAEL RUIZ 4a. Facility Name (If not institution, give stre	eet and number)		4b. City. Town, or	Location of Death	October	23, 2006 4c. County of Deat	2:45 P M
	Examin	er	Clinton Rehab. Nur			Clinton			Prince G	
	Funeral Director		5. Social Security Number 6. Sex 118-14-4439	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 24		hplace (State or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ty, Town or Lo	ocation				10d. Inside City Limits
	death with the Maryland me 23a or 28a-f ehow most be notified at	ctor	Maryland St. Mary's	s Ca	liforn	ia				1 ☐ Yes 2)X No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Co	puntry?
	eath v	Funeral	45824 North Springs	steen Ct. . Was Decedent Ever in L	IS 13.1	20619		ecty Yes or No-	US 14. Race - Ame	ncan Indian.
_	be filed within 72 hours after death with the Marylar Hydiona. did thy filen. did other then "naturely, or iteme 23a or 28a-f ehow event, the Medical Examinar mast be notified at event, the Medical Examinar mast be notified at	by Fun	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:			ispanic Origin? (Spe in, Mexican, Puerto Puerto Ri		Black, Whit	
รุ	72 hou		15. Decedent's Educa (Specify only highest grade of	tion	16a. Dece	dent's Usual Occup			16b. Kind of Business	
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	filed v Hygie ther t	ဝိ	17. Father's Name (First, Middle, Last)	2	LIC CIO	erk	18. Mother's Name	(First, Middle, M	ACCOUN Maiden Sumame)	ting
Maryland		To Be	Miquel Ruiz				Inez Fo	nt		
ar S	s should and Men ie marke sumatic		19a. Informant's Name/Relationship (Type	, Print)	19b. Mailin	ng Address (Street	and Number or Rura	I Route Number	City or Town, State,	Zip Code)
	s 1 and 2 should f Heelth and Mer item 27 ie marke other traumatic		Maria T. Ruiz - Wi						California	
Baltimore,	m O .		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	noval from State MD	cemetery, crei	osition (Name of matory or other place ans ceme		-06	20c. Location - City or Cheltenham	, MD
Ball	permit. Pege Depertment (Important: if eny injury or		21. Signature of Funeral Service Licensee	M01391 ب		2. Name and Addre untt Fune			ld Washing 5, Waldorf	
			23a. Part 1 Enter the disease, or complication shock, or heart failure. List only one							Approximate Interval Between Onset and Death
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ı	Examiner			Due to (or as a conse	quence of):					
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	To the Hospital or Attending Physician: The lawithin 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my ki er: On the basis of examinand manner stated.	nowledge, dear nation and/or in	th occurred at the timestigation, in my o	me, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
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(B391		30. Name and address of person who con 8700 CENTRAL	AV #301		Print) OOVER	MN	2078	5	
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	Regist		OCT 3 0 2	32. Refistrar's Sig	K A	(parts)				

		For Stata Registrar	State of Maryland		rtment of He		Mental Hygie	ZIIIIh	36380
		Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
Physicia	-	Jesse	Lee Riggs				October	30, 2006	4:30 PM
/Medica Examine		4a. Facility Name (If not institution, give s			4b. City, Town, or L	ocation of Death		4c. County of Dea	th
		Citizens Nursing	Home		Frederic	k		Frederi	ick
Funeral			7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo	9. Bir	thplace (State or Foreign
Director		220-18-2404	M 2□F 81	Yrs.	Months Days	Hours Min.		1925 Man	thplace (State or Foreign buntry) Yland
D .	-	Usual Residence of Decedent	100 000	Town and a					Land in on their
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ath v		3637 Kemptown (21770			U.S.A.	
er de	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. V	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (S Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
s aft	Dy L	1 Never Married 2 Married 3 ☑ Widowed 4 □ Divorced	1X Yes 2 □ No If Yes, Give	1	☐ Yes 2X No	Specify:		Specify: Wh	nite
hour lural	<u> </u>		Year or Dates: WWII	10a Danad	ant's Havel Ossumati		10	- Kind of Business	7 d
n 72		15. Decedent's Edu (Specify only highest grade	cation completed)	(Give	ent's Usual Occupati kind of work done du OO NOT use retired)	ring most of wor	king	b. Kind of Business	rindustry
filed within 72 Hygiene. Ither then "naf ent, the Medic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	-	rmer			Farming	5
		17. Father's Name (First, Middle, Last)		14		8. Mother's Nan	ne (First, Middle, Ma	iden Sumame)	
d be so do do do do do do do do do do do do do	10 6	Lester B. Rig	gs			Evely	n Brand	enburg	
should nd Men mark umartic	-	19a. Informant's Name/Relationship (Ty)		19b. Mailin	n Address (Street an				Zip Code) 21770
nd 2 or lith ar lith ar trought		Julie M. Thompson			Kemptown			nrovia, l	
1 and Health tem 27		20a. Method of Disposition	20b. Pl	ace of Dispos	sition (Name of	1		c. Location - City or	
permit. Peges 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other treumatic once.		1 XBurial 2 Cremation 3 R	emoval from State Pro	metery, crem videnc	e Cemeter	y 11/	03/06 Ke	emptown, N	Marvland
ortan Injur	-	4 Donation 5 Other (Specify) 21. Signature of Puneral Service License							
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		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	11.1	1	0 -		7	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	/	1 1	Cardi	al I	- marco	teen	
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ath certific ttending pl or use as t	Š	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar					23d. Date of de	livery
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s bee	Completed						24a. Was an	24b. Were au	utopsy findings available
The le	Ē						autopsy	d2 death?	completion of cause of
	2	25. Was case referred to medical				SE Place of Des	th (Check only one)	No 1 ☐ Yes	2 □ No
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er th	-	27. Manner of Death		28b. Time of	28c. Injury a Work?		28d. Describe how		ony,
Attending or death. ector: After by the funer	at o	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Monin, Day 19ar)	Injury		s 2□No			
Atte	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	eet, factory, office		28t. Location (Street		ural Route Number,
s effection	er	/ / / / / / / / / / / / / / / / / / / /	building, etc. (Specify,	,			City or Town, S	nate)	
Hospital 24 hours Funeral taly filled		29a. Certifier 1 Certifying Phys	sician: To the best of my know	viedge, death	occurred at the time	, date and place	, and due to the caus	e(s) and manner as	s stated.
5 C E E	edical	(Check only 2 Medical Examinations)	ner: On the basis of examinati and manner stated.	ion and/or inv	estigation, in my opir	nion, death occu	rred at the time, date	and place, and due	to the cause(s)
Within To the Comp	Ž	29b. Signature and title of certifier	1		29c. License	number	29d	Date signed (Mont	h, Day, Year)
.0		/mm	~~~ N	20	DS	839		0-31-	-06
HVIX	-	30. Name and address of person, tho	empleted cause of death (Item		Print) 1011		1	- 1	relino
111,		SATTAD AS	212 MD 8	301.	Trall Hz	ouse	Anre.	ned en	104 NM
0					104.1				1,1,1,1

Leroy Michael Royster

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 36381

		1- For State Registrar			Certific	ate of	Death			F	Reg. No.	20	JUI) 00	000
Physicia		Decedent's Name (First, Mid	ldle,Last)						2	. Date of De	ath			3. Time of Dea	ath
ledical Exami		LEROY MI	CHAEL RO	YSTER						Month Novembe	Day er 1, 20	006 Year		0109 hrs	,
		4a. Facility Name (if not institut				41	o. City, Town, o	r Location				. County of	Death		
		6301 Livingston Roa	ıd				Oxon HIII				P	Prince Ge	eorge'	s	
Funcial		Social Security Number	6. Sex	7 Age (in	yrs. last bir	thday)	If Under 1 Ye	ar If Lind	er 24Hrs	8 Date of B	irth (MM/	/DD/////\	9 Birth	place (State o	r Foreign
Funeral Director					Tyro. Idol Dii	inday)	Months Da					1	Cour	ntry)Wash:	ingto
Director		579-90-0622	1 4M 2 F	44		Yrs.				AUGUS	TI	1962	D(C	
_		Usual Residence of Decedent				-		_							
r an		10a. State 10b. Count	у	1100	c. City, Town	n or Locatio	in						- 1	10d. Inside Cit	•
nd shov	卢	MD PRIN	CE GEORGE	'S	OXO	N HIL	Ĺ							1 X Yes 2	. No
daryland 28a-f show any <u>1 at once,</u>	뒿	10e. Street and Number					10f. Zip Code				10g. Citi:	zen of What	t Count	ry?	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene r is marked other than "natural", or items 23a or 28a-f sho ratic event, the Medical Examiner must be notified at once	Director	700/ DOMESTIC	ar DDTITE				007/5								
th th 23a noti		7306 DOMINIC				1.0.11	20745			1		J.S.A.			
th w	Funeral	11. Marital Status 1 X Never Married 2	Married 12. Was De		er in U.S.		Decedent of H s, specify Cuba				0-	14. Race White,		an Indian, Bla	CK,
r dea or it	ᆁ		1 Yes	2 X	No										
after iner	<u>a</u>	·	livorced If Yes, Give Ye or Dates:				Yes 2 X N					Specify:		ACK	
11215-0036 Id be filed within 72 hours after fental Hygiene narked other than "natural". event, the Medical Examiner		15. Decedent's Education (Sp	pecify only highest gra	ade comple	ted) 16a		s Usual Occupa st of working life				16b. k	Kind of Busi	ness/In	dustry	
72 h	Completed	Elementary/Secondary (0-12	2) College	(1-4 or 5+)		during mo	st of working in	e DO NOT	use retiret	u)					
036 thin 72 ne r than	유	12th					COOK					PRIVA	TE		
ed wi	हो	17. Father's Name (First, Midd	le, Last)					18.Mothe	r's Name (F	First, Middle,					
215-0036 be filed within 7 stal Hygiene ked other than ent, the Medica	Be	THEORDORE RO	YSTER_					JO.	ANN	DONOV	AN				
21215-00 nuld be filed wit marked Hygien marked other e event, the M	Ö	19a Informant's Name/Relation			19	b. Mailing	Address (Stre					ity or Town.	State.	Zip Code)	
nore, MD 2 ages I and 2 shou nt of Health and I nt: If item 27 is rother traumatic		JOANN ROYSTER	/MOTHED		1.5	7306 1	DOMINIO	א הפת	VE OX	ON HT	тт	MARVI	ΛND	207/15	
ore, MC ss 1 and 2 s of Health as If item 27	-	20a Method of Disposition	V FIOTHER				ion (Name of co			Date		Location - C			
or Price Pre-			on 3 Removal	from State		tory or other		,				E G G G G G G G G G G G G G G G G G G G	,y v	on,, olalo	
Baltimore, permit Pages Lar Department of Her Important: If ite		4 Donation 5 Other	Specify:		HARMO	ONY C	EMETERY		11/1	.0/06	LAN	DOVER	.MA!	RYLAND	
mit porty ury c		21. Signature Funeral Service		11			me and Addres	ss of Facilit						L HOME	
Pe Pe iii		*) . /	1-hal			74	74 LAND	OVER						20785	5
Physician		23a. Part I. Enter the disease,		caused the	death. Do n									Approximate	
/Medical		failure. List only one caus												Between On Deat	
xaminer		Immediate Cause (Final diseas or condition resulting in death)											\rightarrow	Dead	
		or condition recalling in acaim,	Due to (or as	a conseque	ence or):										
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as	2.00000000	anno of):								-		
	ine	cause. Enter Underlying Caus	e	a conseque	ence or).										
	Examiner	(2196956 or injury that initiated events resulting in death) Las		a conseque	ence of).								-		
nted d ansit		Overla recently in dealiny Edo	d		,										
760, icate be executed physician and the burial - transit	n/Medical	X UNPENDED	AMENDED				F 1						\neg		
760, icate be ex physician the burial	edi			#23a,	<u>27.28a</u> -	-f. per	ME. g862	. 12/1	/06.TT		100	-			
8760, tificate be ng physici as the buri	١	IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes		of pregnancy		al death 3	Ectopi	c pregnanc	21/	230	d. Date of de	lelivery Da	v v	'ear
Se re G		past 12 months?		nant at time	F 1	2 Feta		Ectopi	c pregnanc	-y		Month	De	y I	eai
Box e death c the atten ed for us	.is	1 Yes 2 No 9 U	Inknown	nown		5 Uth	er (Specify)				1				
the d	Physicia	Part II. Other significant cond			t not resultir	na in the ur	derlying cause	given in P	art I	23e Did	tobacco	use contrib	ute to th	ne cause of de	ath?
Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as it	Š		oonangaang	to dodin bu	i i i i i i i i i i i i i i i i i i i	ng in the di	idonying caase	givoiriiri	are i.		es 2		_	ably 4 🗸 Un	
S, F nires	- D	-										140 3		DIY 4 V UII	KIIOWII
required the should	Completed									24a Was				opsy findings a impletion of ca	
e law	튑					-				perf	ormed?	dea	ath?		-
tal Rec	ပိ									1 🗸 Yes	2 N	0 1	✓ Yes	2	No
	Be	25. Was case referred to medie examiner?	Hospital:						(Check on		-1				
of Viiing Physical After this	ပ	1 ✓ Yes 2 No		Inpatient		Dutpatient		Other ₄		Home 5	Reside	ence 6 🗸	Other:	Scene	
Of ing P		27. Manner of Death	28a Dat	e of Injury th, Day,Year)	28b.	Time of In	jury 28c. Inj	ury at Worl	k? 2	8d Describe	how inju	ury occurred	t		
ion tendi	읉		ending vestigation Fnd	11/1/2	006 Fnd	1 12:57	'am l¹∐	Yes 2	No	unkno	ωπ.				
ivisior I or Attend after death Director: d in by the	ij		restigation				, factory, office	building, e	tc 2	8f Location	(Street a	and Number	or Rura	al Route Numb	per, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	ertification:	de	termined (Specify	')	Found	in all	ev		1	or Town, Oxon Hi	State)	_6301 I	ivir	igston Ro	oad
ig spi	O	20a Cartifier													
n 24 n 24 ne Fu	ca	(Check only Certifying	Physician: To the be xaminer:On the basis												
To the Ho within 24 l To the Fur	Medical	h—1	and manner	stated.	ation and o	investigati			occiriod di t	ano timo, dati					
	Σ	29b. Signature and title of cert	ifier				29c. Licen	ise number			29d. I	Date signed	1 (Mont	h, Day, Year)	
		1 as se all	FHA	10	OIN		O.C	.M.E.			Nov	ember 1	, 2006	3	
		30. Name and address of pers	on who completed ca	use of deat	h (Item 23a)		1								
R			ssistant Medica		, ,	Penn S	treet, Baltin	nore. MF	21201						
				Registrar's S					,						
S Regis	tate trar	NOV 08 2				ped									
Regis	ual	HUY UO	- Deve		1										
DHMH 17 Rev 1/2	2001		-		ÓI	RIGINAL									

Replacement

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

•	•	
State of Maryland / Department of Health and Ment	al Hygi	ene
Certificate of Death	Re	a No

2. Date of Death Month 11

2006

4c. County of Death

ALLEGANY

18:50PM M

1			For State Registrar			State	от ма	ıryıan		•	tmer ificat				a M	ien	la
	4		Decedent's Name	(First, Middle,	Last)											2. [
	Physici		VIVIAN MA	RGHERTT	E	котн											Ис .]
	/Medic Examin		4a. Facility Name (II				umber)			- T.	4b. City,	Town,	or Loc	ation of D)eath		_
44			FROSTBUR	G VILLA	GE	NURS	ING	HOME	,		FROS	STBU	JRG				
	Funeral		5. Social Security No	umber 6	. Sex		7. Age	(In yrs.	last birth		If Unde			Jnder 24 ours	Hrs. Min,	8. [a
	Director		234-42-95	36	1 📙	M 2∏ F			76 Y	rs.	VIOLITIES	Day.		ours i	VIII.	1	M
	p		Usual Residence of					10- 04	Tau-		A!		_				_
	e Maryla a-f shov	ctor	10a. State MD	10b. County ALLEGA	NY				y, Town STBUI		llion						
	n with the	ai Director	10e. Street and Nun		LA	NE					10f. Zij 2	Code					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23s or 28s-1 show any injury or other traumatic event, Its Modical Ever it or mantice and iffed at ances.	by Funeral	11. Marital Status 1 Never Marrie 3 Widowed			2. Was De Armed F 1 Tes If Yes, G Year or	orces? 2 📉 N Sive		.s.		as Dece /es, spe			nic Origin lexican, F	? (Spe	ecify Rica	Yen,
8	hou			15. Decedent's	Educ		- Catos.		16a. I	Decede	nt's Usu	al Occ	upation				_
15	in 72	piet		ify only highest	gra de	completed				(Give ki life. DC	nd of wo	ork don ise retii	e dunn red)	g most o	worki	ing	
212	s with	Completed	Elementary/Secon	ndary (0-12)		College	(1-4or 5-	+)	CT	ERK							
9	e file I Hyg othe	BeC	17. Father's Name (First, Middle, La	ist)								18.	Mother's	Name	e (Fir	st
ā	Henta Fenta Ked	To B	JAMES WII	LIAM MC	KE	NZIE							HA	NNAH	E.	. V	I
a	shou and M and M a ma	_	19a. Informant's Na	me/Relationship	о (Тур	oe, Print)			19b.	Mailing	Addres	s (Stre	et and I	Number o	r Rura	al Ro	ut
Σ	alth a		GEORGIAN	INA HAMM	ON	D/DAU	GHTE	R	11	WES	T OF	RANC	GE C	COURT	' BA	ALI	1-
Baltimore, Maryland 21215-0036	Pages 1 annent of He ant: If Itan ury or oth		20a. Method of Disc 1 Burial 2 4 Donation	Cremation 3		emoval fror	n State	4	Place of cemetery IBERI	r, crema	itory or	otner p		7 11	-3-	Date -2()(
a	permit. Departr Importa		21. Signature of Fu	Prat Service	cense	99				22.	Name a	nd Add	ress of	Facility			
m —	995 59		1 46	en M/	ou	ur	ma	054	14	SO	WER	S FU	UNE	RAL F	IOMI	Ε,]
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.						ot enter	the mo	de of d	ying, su	ich as ca	rdiac d	or res	p	
	Physician		Immediate Cause (disease or condition	Final n		M	alig	nav	t	3	ym	νh	om	a			
	/Medical Examiner		resulting in death)	1	r "	Due to	o (or a	consec	quence o		1	+	a pro				
	ed .	iner	Sequentially list confidence if any, leading to improve the cause. Enter United Cause (Disease or	nditions, mediate flying	b		o (orasa	a consec	quence o	f):							
oʻ	tificate be executed g physician and as the burial-transif	Examin	that initiated events resulting in death) I		С	Due to	o (or as a	a consec	quence o	f):							-
68760,	icate be physici s the bu	edicai			d												_
. Box (eath certif attending for use a		IF FEMALE: 23b. Was decedent in the past 12		2:		birth	2 Feta	al death		ctopic p						
o.	the a	/sic		No		4∐Pre 9□ Unk	gnant at (nown	time of o	death	5 🗆 (Other (s	oecify)					_
	s that the ned by a detac	by Physician/M	Part II, Other signif		s con	tributing to	death bu	ut not res	sulting in	the und	derlying	cause (given in	Part I.		T	2
ords	require een sig hould b	Completed b													-		
sec.	e law has b e 2 si	npie	-												_		2
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712	lcian sertifi ector	Be	25. Was case refer examiner?	red to medical	-	lognital:								. Place of	Deat	h (Cl	10
5	hysh this c	은	1 Yes 2 🔀		Н		Inpatie		ER/Out		3 D	UA		4 Nursi	-		5
Division of Vital Records, P.O	or Attending Physician: The law requires that the death cer after death. Director: After this certificate has been signed by the attendir in by the funeral director, page 2 should be detached for use	ertification:	27. Manner of Deat 1 Natural 2 Accident	5 Pending investiga	tion	28a. Dat (Mo	e of Injui onth, Day	y Year)	28b. T	ime of ijury	М		rork?	2 🗆 No		28d.	D
Divis	I or Attendi after death. Diractor: A	ertific	3 Suicide 4 Homicide	6 Could no determin	ot be led	28e. Pla bui	ce of Inju	ury - At h	nome, far	m, stree	et, factor	y, offic	9		T	28f.	C

	12 2	9 I	929	FRO	STBURG, MD
					10d. Inside City Limits
					1 □ Yes 2 🛣 No
		10g. C	itizen of	What Co	untry?
		UNI	TED		
anic Origin? (Spe Mexican, Puerto	ecify Yes or No Rican, etc.))-		ce - Ame	rican Indian, e, etc.
Specify:			Specif		HITE
on ing most of worki	ing	16b.	Kind of B	lusiness/	Industry
			ETAI		
8. Mother's Name					
IANNAH E.					
d Number or Rura		_ `			cip Code)
	ALTIMOR	_			Tour Chair
1	Date				Town, State
RY 11-3-	-2006		BERL.	-	-
of Facility			W.]		
ERAL HOMI	E, P.A.	FR	OSTB	URG,	MD 21532
such as cardiac o	or respiratory a	rrest,			Approximate Interval Between Onset and Death
na					one year
				ate of deli	ivery Day Year
-			1910	OTHE !	Day 1841
in Part I.	23e. Did	tobacco	use con	tribute ta	the cause of death?
	1 🗆	Yes	2 🗆 No	3	obably 4 Unknown
	24a. Was auto perfe 1 Yes			Were au prior to death?	utopsy findings available completion of cause of
26. Place of Deatl					
4 Nursing Ho			6 □Otl	her (Spec	cifv)
	28d. Describe				J /
	28f. Location (City or To	Street a	and Num ite)	ber or Ru	ural Route Number,
, date and place, sion, death occurr					
umber		29d. D	ate signe	ed (Monti	h, Day, Year)
5325		1/1	OV O) 2	2006
JJ~J		12	D A C	4,	2000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and du 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tandmanner stated. 29c. License number

00055325

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHIN WONSOCK 31. Date filed (Month, Day, Year) NOV 1 7 2006

worsafelle

29b. Signature and title of certifier

48 Tarn Tenuce Registrar's Signature

M.D

Frostburg

MD 21532

State Registrar

DB

nds

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The law requires that the

s after death.

I Diractor: Af
d in by the fur

within 24 hours a To the Funeral D

5

Certification:

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day 2006 Mable 10:05 A M May Rosier Nov. 8, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Towson

10f. Zip Code

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Care

7. Age (In yrs. last birthday)

10c. City, Town or Location

Parkton

76

Baltimore

10g. Citizen of What Country?

9. Birthplace (State or Foreign Country)
Maryland

10d. Inside City Limits 1 ☐ Yes 2 No

8. Date of Birth (Month, Day, Year)

Jan. 1, 1930

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Gilchrist Center for Hospice

Baltimore

10b. County

6. Sex

5. Social Security Number

10e. Street and Number

10a. State

MD

216-30-2253

Usual Residence of Decedent

Physician /Medical Examiner

law requires that the death certificate be executed physician and s the burial-tran Division or Vital Records, P.O. Box 68760, signed by t d be detach page To the Hospital or Attending Physician: After thi within 24 hours after death

To the Funeral Director: A

<u>a</u>	1303 Armacost	t Road		21120		l t	J.S.A.	
runera	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S. 13.	Was Decedent of Hisp. If Yes, specify Cuban,	anic Origin? (Spec Mexican, Puerto B	cify Yes or No-	14. Race - Ame Black, Whit	
	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1			Specify:	,,	Specify: Wh	-
Completed by	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	16a. Dece	dent's Usual Occupation with kind of work done during DO NOT use retired)	on ing most of working	16b.	Kind of Business	/Industry
E O	Elementary/Secondary (0-12)	College (1-4or 5+)		bo NOT use retired) sembler			ool Mfg	· •
	17. Father's Name (First, Middle, Last)			18	3. Mother's Name ((First, Middle, Maide		
o Re	Howard Frank	lin Patterso	n		Hilda Co	ora Virgir	nia Mil	lender
	19a. Informant's Name/Relationship (7	Type. Print)	19b. Maili	ng Address (Street and	d Number or Rural	Route Number, City	or Town, State, 2	Zip Code)
	Melvin K. Rosier,	Jr./Son	130	l Armacos	t Rd.,	Parkton	, MD 21	120
	20a. Method of Disposition	20b. P	lace of Dispe	osition (Name of matory or other place)	Da	ate 20c.	Location - City or	Town, State
	1 X Burial 2 □ Cremation 3 X 4 □ Donation 5 □ Other (Specify	Nev	v Free	dom Cemeter	У 2006		w Freedor	
	21. Signature of Funeral Service Licen	Muna		24 Secon	d St.,	New Free	stein M	ortuary,Inc A 17349
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not en	ter the mode of dying,	such as cardiac or	respiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	1		ic mel				Onset and Death
	resulting in death)	Due to (or as a consequ		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			0
	Coquantially list conditions	b. =						
je l	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):					
a	that initiated events	C						
Ĭ	resulting in death) Last	Due to (or as a consequ	uence of):					
E3		d						
sician/Medical Examiner	IF FEMALE:							
an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna	death 3	□ Ectopic pregnancy	23d. Date of delivery Month Day Year			
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5	Other (specify)			World	Day
/ Phy	Part II. Other significant conditions of	ontributing to death but not resi	ulting in the u	underlying cause given	in Part I.	23e. Did tobacco	use contribute to	o the cause of death?
Completed by						1 ☐ Yes	2 ₫ Ño 3□P	robably 4 \(\sum \sum \text{Unknown} \)
olete						24a. Was an	24b. Were a	utopsy findings available completion of cause of
Ē						autopsy performed 1□ Yes 2□	death?	
Φ	25. Was case referred to medical				26. Place of Death		10 1016	2 110
TO B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie			ne 5 Residence	6 Mother (Spe	ecity) Hospira
	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injury a Work?	t 2	8d. Describe how in	jury occurred	T.C.
ation:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		піјагу	I	s 2 No			
Medical Certifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, st	treet, factory, office	28	8f. Location (Street City or Town, St		tural Route Number,
o a	29a. Certifier 1 Certifying Ph	nysician: To the best of my kno	wledge, dea	th occurred at the time	, date and place, a	and due to the cause	(s) and manner a	s stated.
gic	(Check only 2 ☐ Medical Exar	niner: On the basis of examina and manner stated.	tion and/or i	nvestigation, in my opin	nion, death occurre	ed at the time, date	and place, and du	e to the cause(s)
ž	29b. Signature and title of certifier	10		29c. License n	umber		Date signed (Mon	
	My Hothm	Johny, "	10	023	.902	No	ventre	n 8, 2006
	30. Name and address of person who	6 Bmc	5701	N-Cher	la 57	Ech	s. ind	n 8, 2006 21204
e ar	31. Date filed (Month, Day, Year) NOV 1 5 20	32 Jegistrar's Signa	ture A	nack				
01		A	1					

Registr DHMH 17 Rev 1/200

Sta

	-	For State Registrar	State of Marylar		artment of F				36391.
Physicia /Medic		1. Decedent's Name (First, Middle, La	51LB	ERF	ARB		2. Date of Death	Day 28, 200	3. Time of Death 9,10 AM
Examin	- 11	4a. Facility Name (If not institution, given Hebrew Home of	e street and number)	·	4b. City, Town, o		ר	4c. County of De	
Funeral Director		000-52-5033		last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	9. B 1903 P	irthplace (State or Foreign Country) oland
Maryland I-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo		ity, Town or Lo					10d. Inside City Limits
bith with the Marylan 23s or 28s-f show	Funeral Director	10e. Street and Number 6121 Montrose Roa		OCKVIII	10f. Zip Code 20852		100	U. S. A.	Country?
d 21215-0036 filed within 72 hours after deeth with the Maryland Hygiene. wher then "natural", or Items 23a or 28s-1 show int, the Medical Exeminar must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Tyes 2 DNo If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	nerican Indian, lite, etc. hite
ING 21215-0036 be filed within 72 hours after dee lial Hygiene. od other than "natural", or items event, the Madical Examination	Be Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12 Years	ducation ade completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking 16	b. Kind of Busines	
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Md 2 nd 2 lith a lith a 27 is rirak		19a. Informant's Name/Relationship (Robert M. Silbert	farb - Son	174 N	New Mark			le, Mary	land 20850
Page ry		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State (y)	cemetery, crer haron (estion (Name of matory or other plac Gardens	10/3		alhalla,	New York
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Cords, P. w requires that been signed by	ρ	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.		1	to the cause of death? Probably 4 □Unknown
al Records, The law requires to cete has been signe, page 2 should be on	Completed						24a. Was an autopsy performe	prior to death	autopsy findings available occumpletion of cause of essential No.
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To the within 2 complete	M	29b. Signature and title of certifier Bowline	e Gold	ly	29c. Licens		6 De	1. Date signed (Mo	nth, Day, Year) 2
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			For State Registra/MEND#23a(b)	perMD10/31/0	6,BMW,MbCb	Certifica	te of	Death	1 -	F F	Reg. No.	000	36385	_
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	Medica camine		Myrtle Gordon S 4a. Facility Name (If not institution,		oer)	4b. Cit	y, Town, o	r Location o	of Death	10	4c. Cc	OCo ounty of Deatl	0009	_
-	.amme	5 1	Suburban Hospit				Beth				Мо	ntgome	rv	
Fun	eral				Age (In yrs. last bi	rthday) If Und		If Under a	24 Hrs. 8. Min.	Date of Birtl (Month, Day	h /, Year)		hplace (State or Foreign untry)	_
70	ctor		578-12-6609 Usual Residence of Decedent	TOM ZIAF	09	Yrs.			S	Sept 1	6, 19	17 Wa	shington, D	C
ylar	3	_	10a. State 10b. County		10c. City, Tow	m or Location							10d. Inside City Limits 1 ☐ Yes 2 X No	
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ĕ ≗	9	Ē	1 Never Married 2 Marrie	Amed Force 1 Tes 2 If Yes, Give			ecity Cuba 21√2 No	an, Mexican Specify:	i, Puerto Rio	can, etc.)		Black, White	e, elc.	
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should be nd Mental marked o		ToB	Robert Gordon					Franc	ces Un	nobtain	nab1e			
aryla should and Men	traumatic		19a. Informant's Name/Relationshi	o (Type, Print)	191	b. Mailing Addre	ss (Street	and Numbe	er or Rural R	loute Numbe	r. City or T	own, State, 2	Zip Code)	
	other tr		Joel Kawer/Son-	-In-Law		37 Kerst		t, Gai						
Ses 1	ō		20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3	Removal from St		of Disposition (N ery, crematory or	lame of r other plac	сө)	Date	9	20c. Loca	ition - City or	Town, State	
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Dermit.	any inju		21. Signature of Funeral Service	D 774.0	0.0							uneral		
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			23a. Part1. Enter the dilease, or c shock, or heart failure.								1031,		Approximate Interval Between Onset and Death	
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t the d	ched	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov		3 G Other (3poony) _							
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The law requires	page 2	E								autop perfor 1 Tyes	rmed?	death?	completion of cause of	
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ding P			27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of (Month)		Time of Injury	28c. Injur Wor	ry at rk?	280	d. Describe h	now injury	occurred		
or Attending ter death	the funer	cati	2 Accident investiga 3 Suicide 6 Could no	t ho	16 1004	М		Yes 2 □ I						
7 7 0	ii.	Certification;	4 Homicide determin	289. Place C	f Injury - Al home, f g, elc. (Specify)	arm, street, facto	ory, office		281	City or Tox	Street and i vn, State)	Number or Ru	ral Route Number,	
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To the Hospital within 24 hours e	comp	Me	29b. Signature and title of certifier	H.	~ ^	2		se number		11-		signed (Monti		-
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d		1	30. Name and address of person w		of death (Item 23a)	(Type, Print)						÷		
			MARTI		7-11.1	8600	01d	George	etown	Rd, B	ethes	da, MD	20851	
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			1 - For State Registrar	State of Marylan	d / Depa	artmer	nt of H		nd Me		Reg. No.	200	16	36386
	Physicia /Medic	al	Decedent's Name (First, Middle, Las Vera Elizabeth R Aa. Facility Name (If not institution, give	oman Sessions		4h Cibe	Town or	Location of	(2 Date of De Month October	Day 22,			3. Time of Death 5:35 P M
	Examin	er	14 Golden Eye C 5. Social Security Number 6. Se	7. Age (In yrs.	last birthday) Yrs.	0c	ean I	Pines		8. Date of Birl (Month, Da Jan 24	Wo	rcest	er Birthpl Count	ace (State or Foreign
**	Director	_	421-52-3453 Usual Residence of Decedent 10a. State 10b. County MD Worches	93	y, Town or Lo					Jan 24	,191.	3 F	Alab	d. Inside City Limits
ode deine	a or 28s-f	Directo	10e. Street and Number 14 Golden Eye Ct		.ean 11	10f. Z	p Code				-	en of What		-
La Constantin de Constantin de Constantin	portion is ago it said and Mantal Hygiene. Important: or items 23s or 28s-f show any injury or other traumatic event, the Madical Examinational by notified at once.	by Funeral	11 Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1		edent of Hi ecify Cuba	spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No Rican, etc.)	- 1	4. Race -	America White, e	an Indian, itc.
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			30 Name and address of person who	M.D. 11107 Rac	etrack	RD,		n,MD	2181	1				
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			For State	State of Man	yland / De	epartmen Certificate	t of H	ealth and M Death		Sm U C) 6	36387	
			Registrar 1. Decedent's Name (First, Middle, Las.	t)		- Timouri	00, 2	, outr	2. Date of Death	. NO.		3. Time of Death	
	Physicia	*	Robert L. St	rother					October	Day 25 20	Year 106	1710 M	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of Death	OCCOBET	4c. County		1/10	
	Funeral	e.	Ft. Washington 5. Social Security Number 6. Se	n Hospital	n yrs. last birtho	fay) If Under	Ft.	Washing If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear)	9. Birthpl Count		
Ļ	Director		223-34-3717 Usual Residence of Decedent		80 Y	s.			Apr. 10,	1926	Vi	rginia	
	land ow		10a. State 10b. County	10	Oc. City, Town o	r Location					10	Od. Inside City Limits	
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	deeth with the Maryland me 23a or 28e-f ehow r must be hollfled at	Funerai	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Deced	ent of His	spanic Origin? (So	ecify Yes or No-	14. Race	- America	an Indian,	
2-0036	s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other then "natural", or Iteme 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2		Specify:	Hican, etc.)	Specify:		ican rican	
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yland	Mend arke	ဥ	Charlie Str	other					Annie B	etty B	leck		
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Balt	permit. Peges 1 and Depertment of Health Important: If Item 21 eny Injury or other to		21. Signature & Funeral Service Licens	Sterrent	TT-	22. Name and		s of Facility Benning		uneral Wash.,			
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о Э	w requires that the death certiff been signed by the attending should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at tim 9☐ Unknown		5 ☐ Other (spe				Mor	nth	Day Year	
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\leq	al or Attending F setter death. I Director: After d in by the funera	ertification;	4 ☐ Homicide determined	building, etc. (Specily)	,,,	, 000		City or Town, S	State)			
_	To the Hospital or within 24 hours ette To the Funeral Dir completely filled in	O	23a. Certifler 1/2 Certifying Phy	ysician: To the best of n	ny knowledae i	leath conworks	at the tion	e, date and ritana	and dust to the main	sala) and one	The second	wet.	
	24 h 24 h Fui etely	edicai	(Check only 2 Medical Examone)	iner: On the basis of ex and manner stated	amination and/	or investigation,	in my op	inion, death occurr	ed at the time, date	and place, a	nd due to	the cause(s)	
	vithin of the	Me	29b. Signature and title of certifier			29c	License	number	29d	. Date signed	(Month, £	Jay, Year)	
	7) ce	Min.		\mathcal{L}	00	37066		0/23	7/20	06	
\cap	(1)		30. Name and address of person who o	empleted cause of deat	h (Item 23a) (To	rpe, Print)		1			,		
1	6	1	Uchech: T. Doar.	EOCV, MO	61881)	con H	11 R	1#701 0x	on Hill, m	120	7-4	5	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		-1 - 0	1	· · · · · · · · · · · · · · · · · · ·	1200	/		
	Registr		OCT 31 2006	Bear !	4. Ope	B							

			For State	. 104	Sta	ate of	Marylaı	nd / Depa		t of H	ealth a	and M	ental Hyg		2 11 11 6	30	5388
			Registrar 1. Decedent's Name	(First, Middle	Last)				runcai	e or L	Jealii	1	2. Date of Dea	eg. No	000		ne of Death Aw
	Physicia		Edith	М.		hade	ž						Month	Day	Zoo 6		
	/Medio Examin		4a. Facility Name (If						4b. City,	Town, or	Location	of Death	001,	4c.	County of Dea		
			Washin		Count	у Но	spit	al			stow				Wash	ingto	n
	Funeral Director		5. Social Security Nu 235-12- Usual Residence of	1211	6. Sex 1 ☐ M 2			. last birthday) 88 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 03/28				ate or Foreign rginia
	yland		10a. State	10b. County			10c. C	ity, Town or Lo	ocation							10d. Insid	le City Limits
	e Mar	ctor	WV	Berk	eley		M	artins	sbur	9						1 🗆	Yes 2⊠No
	be filed within 72 hours after death with the Maryland tal hygiene d other then "natural", or itams 23a or 28a-f ahow avant, the Medical Examinat must te motillad at	Funeral Director	10e. Street and Num 150 Myr		r.				10f. Zip	2540	5			10g. Citi. US.	zen of What C	country?	
	deatl	ner	11. Marital Status		12. W	as Deced	ent Ever in t	J.S. 13.	Was Dece	dent of Hi	spanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - Am		n,
2-003p	hours after tural', or ita	by	1 ☐ Never Marrie		ed 1 If	Yes 2 Yes, Give	⊠ No	1	1 ☐ Yes		Specify:		ritoari, oto.,		Black, Wh Specify: WI		
ה ה	72 ho	Completed	(Speci	15. Decedent fy only highes	's Education	n npleted)		16a. Dece	dent's Usu	al Occupa	ation Jurina mos	st of worki	na	16b. Ki	nd of Busines	s/Industry	
7	within 72 ene. then "nai	ap I	Elementary/Secon		1	ollege (1-4	tor 5+)	1	kind of wo DO NOT u)		9	_			
17.	filed v Hygie other t		12 17. Father's Name (First Middle	l astl			O _]	pera	tor	18 Moth	er's Name	(First, Middle,		lepho	ne Co	· •
yland	should be tind Mental I	To Be	Floyd B)							rtrude				
Mar	Pages 1 and 2 should ment of Heelth and Men ant: If Itam 27 Ia marke jury or other traumatic		19a. Informant's Na Jane M.				tor		_				insbur				
-	1 and Heeli Iam 2	H	20a. Method of Disp		5 / DC	lugii		Place of Dispo	osition (Nai	me of			Date		cation - City o		e
<u></u>	Pages nent of int: If It		1 Burial 2 ☐ 4 ☐ Donation			al from Si	ate	cemetery, cre.		•	· 1	10/2	8/06				
Baltimore,	# # # # # #		21. Signature of Fur										sedale				
ă	Dep Impo		The state of the s	. K. a	the	Z.		1000					, Mart				
	Physician		23a. Part . Enter the short, or hear	Final	complication only one cau	ns that car use on ear	used the dea ch line.	ath. Do not en	ter the mod	de of dying	g, such as	cardiac o	or respiratory ari	rest,		Onset	imate Between and Dea
	/Medical		ulting in death)		_ a. ∱	Due to (o	r as a conse	quence of):	ug	reur	ar	alli	sens			5 m	inely
	Examiner		Sequentially list cor	nditions.	b												
	ed sit	ine	if any, leading to im cause. Enter Under Cause (Disease or	any, leading to immediate use. Enter Underlying													
	ite be executed sysicien and ne burial-trensit	Examiner	cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):														
/eC	te be e ysicien ie buris	calE															
ĝ	ifficate g phy as the	-			0												
X Q Q	eath certificat ettending phy I for use as the	M/u	IF FEMALE: 23b. Was decedent				ome of pregi		⊒Ectopic p	ragnanov					23d. Date of d		
о	The law requires that the death certifica sie hes been signed by the ettending ph bage 2 should be deleched for use as if	Completed by Physician/Med	in the past 12 1 ☐ Yes 2-2 9 ☐ Unknown		4		nt at time of		Other (s						Month	Day	Year
٦.	thet the de ned by the e deteched t	P.	Part II. Other signifi	cant condition	ns contribut	ting to dea	ith but not re	sulting in the i	underlying (ause dive	an in Part I		23e. Did to	bacco u	se contribute	to the cause	of death?
Records,	signe signe d be	d by	DARRALL	linein		/		isbet	1	,		•		es 2			I ∐Unknown
င္ပ	w require been si should t	lete		-	77		7.0	and the same					24a. Was	30	24h Were	uitonsy find	nos available
Š	vsician: The lavis certificate hes director, pege 2	m o		-									autop perfor	sy med?	death?		ngs available of cause of
Vital		0	25. Was case refer	red to medical					_		26. Place	e of Death	1 ☐ Yes	-	1 □ Y€	s 2 No	
	nysici nis cer direc	To B	examiner?	No	Hospit	tal: 121n	patient 2[☐ ER/Outpatie	nt 3 🗆 D	Othe Othe	200		me 5 ☐ Resid		6 □Other (Sp	ecity)	
0 00	Attending Physician: It death. actor: After this certific by the funeral director.		27. Manner of Death	5 Pendin	g	a. Date of (Month	Injury , Day Year)	28b. Time o Injury	of :	28c. Injury Work 1 □ `	rat c? Yes 2 □		28d. Describe h	ow injur	y occurred		
Division of	2 th 2 ⊆	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify)						y, office			28f. Location (S City or Tow	itreet an m, State	d Number or F)	Pural Ploute	Number,	
_	e Hospitat or 24 hours ette a Funeral Dir letely filled in		29a. Certifier (Check only	1 Certifyin	g Physician	n: To the t	pest of my kr	nowledge, dea	th occurred	at the tim	ne, date ar	nd place,	and due to the	cause(s)	and manner	as stated.	
	To the H within 24 To the Fi complete	Medical	one)		a	and manne	er stated.	ation and/or if				au occurr	red at the time,				
	To To Con	2	29b. Signature and	title of certifie	+				29	c. License				29d. Dai	te signed (Mor	nth, Day, Ye	ar)
•			[No	men	/				8)32	5/8			10/	25/26		
4	4-5		30. Name and addr	Suld!	wno comple	ned cause	or death (Ite	em 23a) (Type	. Print)	10	Val	1.	ulle	mI	_ 2 .	70	
	Sta	ate	31. Date filed (Mon				gistrar's Sigi	nature	1800	٠٠ــــ	LLL	ays	me /	Md	3/	(06	
	Regist	rar		OCT 3	1 2006	A	200 mg	1. 1	nerte	,							

			1 - State of Maryland / Department of Certificate of Registrar			2006	36389								
	Physicia	an	Decedent's Name (First, Middle, Last) One of the control of		Date of Death Month	Day Year	3. Time of Death								
	/Medic	al	JOSEPH MARTIN STANG, SR. 4a. Facility Name (If not institution, give street and number) 4b. City, Tow	m, or Location of Death	OCTOBER	26, 2006									
	Examin	er	11336 QUAILBRIDGE CIRCLE	HAGERSTOW	N		SHINGTON								
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth JUNE 9,	9. Bir 920 MAR	hplace (State or Foreign Suntry) (LAND								
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits								
	Maryli 1 sho	ō		FREDERICK			1 ☐ Yes 2 ☐ No								
	ith the Marylar or 28e-1 show	Director	10e. Street and Number 10f. Zip Cod		10	g. Citizen of What Co	ountry?								
	death with the Maryland ms 23a or 28e-f show franst ke guille dan		5955 QUINN ORCHARD ROAD	21704		U.	S.A.								
۵	72 hours after death with the Maryla "naturel", or Items 23a or 28e-f shov	Funeral	Armed Forces? If Yes, specify (of Hispanic Origin? (Spe Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit									
2-003p	n 72 hours after "naturel", or Ite	d by	3 X Widowed 4 □ Divorced Year or Dates: 1945				HITE								
7		Completed	life. DO NOT use re	one during most of work	ing 1	6b. Kind of Business	findustry								
717	d with giene.	Com	Elementary/Secondary (0-12) College (1-4or 5+) CAR	PENTER		WOOI	OWORKING								
yland	uld be filed within tental Hygiene. Ked other than tice event, II e M	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M	aiden Sumame)									
C.	2 should be and Mental Is marked e	은	GEORGE WASHINGTON STANG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (St.		BEATRICE		Tin Code I								
<u> </u>	s 1 and 2 should f Health and Men item 27 is marke other treumatic			LBRIDGE CIR		-	1								
Se,	of Health of Health litem 27		20a. Method of Disposition 20b. Place of Disposition (Name of Computer of Comp	of [Dc. Location - City or									
Baltimore,	Pages ment of tant: If it		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) PARKLAWN MEM. P.	1 1 1 1 1 1 1 1 1	/2006	ROCKVILLE	MARYLAND								
Rail	permit. Pages Department of I Important: If its any Injury or of once.		1 10/16	ddress of Facility UNERAL HOME	7606 OL	D NATIONAI RO, MARYL	PIKE								
			23a. Part it Exter the disease or complications that caused the death. Do not enter the mode of shock or heart failure. List only one cause on each line.	dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death								
	Physician /Medical		Interval Bronset and Interval												
	Examiner		Due to (or as a consequence of): Coudro my op ath y												
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	1009											
	icate be executed physicien and the burial-transit	Examin	resulting in death) Last C. Due to (or as a consequence of):												
9/8	ysicier	dicail	d												
9		Med	IF FEMALE:												
O. Box	at the death certifi by the attending tached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 \[Yes 2 \] No 9 \[\] Unknown 23c. If yes, outcome of pregnancy 1 \[\] Live birth 2 \[\] Fetal death 3 \[\] Ectopic pregn 4 \[\] Pregnant at time of death 5 \[\] Other (specification of the content of			23d. Date of de Month	livery Day Year								
٦.	res that the igned by be detact	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.	23e. Did toba	acco use contribute to	the cause of death?								
rds	aquires en sigr ould be				1 🗆 Yes	3	robably 4 Unknown								
Records,	: The law requires that the cate has been signed by the page 2 should be detache	Completed			24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of								
Vital	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?		h (Check only one										
0	Physician: this certifical	. To	1		ome 5 Resider		Daughter's rest ence								
lon	nding Phi th. : After this funeral	tlon	1 Natural 5 ☐ Pending (Month, Day Year) Injury	Injury at Work? 1 Yes 2 No	200. Describe not	virially occurred									
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	fice	28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,								
	To the Hospital within 24 hours a To the Funerel I completely filled	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the action of the basis of examination and/or investigation, in and manner stated.	ne time, date and place, my opinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)								
	within To th	Me	29b. Signature and title of certifier 29c. Li	cense number	29	d. Date signed (Moni	h, Day, Year)								
•				060417	1	0/27/0	6								
5H	-3+1			m DV Fr	redenica	MD 2	1702								
	Sta Regist		31. Date filed (Month, Day, Year) OCT 3 0 2006 32. Registrar's Signature												

		•	1 - For State Registrar	State o	f Marylar		artmen rtificat			and Me		jiene,	2005	363	390
	Dhysiai	200	1. Decedent's Name (First, Middle	, Last)							2. Date of Dea Month	ith Day	Year	3. Time of	Death
	Physicia /Medic		Orval Richard S								Oct.	29	2006	7:38	A ^M
)	Examin	er	4a. Facility Name (If not institution		mber)				Location o	of Death			County of Death Washing	ton	
	Euparal		Beverly Health 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	gers 1 Year	If Under a	24 Hrs.	8. Date of Birth (Month, Day			olace (State o	r Foreign
	Funeral Director		216-22-7864	1 ∑ M 2□F	79	Yrs.	Months	Days	Hours	Min.	(Month, Day 10/03/1	, Year) 92.7	Cou	vitry) V	
	9		Usual Residence of Decedent 10a. State 10b. County		100 C	ty, Town or Lo								I Od. Inside Cit	
	faryla shov	5		ngton		Hagers								1 & Yes	-
	28a-1	rect	10e. Street and Number	1160011		падсты	10f. Zip	Code	-			10a. Citiz	en of What Cou		
	death with the Maryland me 23a or 28a-f show r must be notified at	Funeral Director	717 W. Washingt	on Stree	t			217	40			U		,	
	death	nera	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Dece	dent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	1	4. Race - Ameri Black, White,		
2	or its		1 Never Married 2 Marri	ed 1 [X]Yes If Yes, Gi	2 □ No ve		1 🗆 Yes		Specify:	, 1 40110 1	iloari, etc.)			hite	
Š	72 hours efter natural', or ite dical Examine	ed by	3 ☐ Widowed 4 🔯 Divorced	Year or E	ates:	16a. Dece			ation						
<u>.</u>	in 72 n "na Aedic	Completed	(Specify only highes	t grade completed)	4.45.)	(Give	kind of wo	rk done d	during most	t of workin	g	IOD. KIII	d of Business/Ir	dustry	
7	d within giene. or then "	E	Elementary/Secondary (0-12)	College (1-40r 5+)		Dry	Clea:	ner				Dry Cle	aning	
2	el Hyg	Bec	17. Father's Name (First, Middle,								(First, Middle,		Sumame)		
N N	should bind Ment	5 T	Samuel Johnson Shillingberg Eliza Ellen Bo												
, Mar	and 2 shi selth and n 27 le m		19a. Informant's Name/Relationsh Richard W. Shi		/ Son								MD 217		
nore	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Heelih and Menlet Hygiene. Integration of Heelih and Menlet Hygiene. Integrate it if ama 21 is marked other than 'naturali, or iteme 23a or 28a-f show any njury or other traumatic event, the Madical Examinar must be notified at OBEs.		157 Burial 2 Cremation 3 Demoval from State cometery, crematory or other place)								Location - City or Town, State gerstown, MD				
Saltimor	permit. P Departme mportan tny njur		21. Signature of Euneral Service I			22	2. Name ar	d Addres	s of Facility	y Ge	rald N.	Min	nich Fu	neral 1	
	40244		23a. Part1. Enter the disease, or	complications that	raused the dea								own, MD	Approximate	
	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on	each line.	sclor	atu		-				Discose	Onset and I	ween Death
	/Medical Examiner		Due to (or as a consequence of): Dialute Renal Dia						Dize	ase	rosaula			240	1.45
_	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):	puence of):										
_	certificate be executed ding physician and use as the burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a consec	quence of):									
2/00	s be e Sician buria	ical E			`										
00	ificate g phy: as the			d											
ž Q	th cert endin r use	an/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn]Ectopic p	reonancy				2	3d. Date of deliv	,	
_	w requires that the death certifics been signed by the attending pl should be deteched for use as t	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of		Other (sp						Month	Day 1	Year
Z.	that the ad by detec	Ph	Part II. Other significant condition	ns contributing to c	leath but not re:	sulting in the u	nderlvina d	ause dive	en in Part I.		23e. Did to	bacco us	se contribute to t	he cause of d	leath?
ecords,	law requires that the es been signed by th 2 should be deteche	d by									1 🗆 Y	′es 2 [No 3∏Pro	pably 4 🛛	Jnknown
5	s beer	Completed									24a. Was		24b. Were auto	opsy findings	available
Ē	Physicien: The lav this certificate hes al director, pege 2	E O									autop perfor		death?	mpletion of c	ause of
VIII	ortifica ctor, I	Bec	25. Was case referred to medical examiner?							of Death	Check only or				
5	Physic this co	ပ္	1 ☐ Yes 2 No			ER/Outpatie			4KS NU				□Other (Speci	fy)	
	ding P th. : After 1 funera	Certification:	27. Manner of Death 1 Matural 5 ☐ Pendin 2 ☐ Accident investig	4	of Injury oth, Day Year)	28b. Time o Injury	f M	28c. Injury Work 1 □ `	/at ∢? Yes 2 🔲 I		8d. Describe h	iow injury	cocurred		
DIVISION	Attence or death rector: by the	ifica	3 Suicide 6 Could i	not be 28e. Plac	e of Injury - At h	nome, farm, st							l Number or Plur	al Route Num	ber,
2	tal or	Cert	4 Hornicide	Dulic	ling, etc. (Speci	my) 					City or Tow	m, State)			
	To the Hospital or Attending Physicien: which 24 hours siter death size this certifics To the Funerel Director: After this certifics completely filled in by the funeral director; is	edical	29a. Certifier 15 Certifyin (Check only 2 Medical one)	g Physician: To th Examiner: On the t and mai	e best of my kn pasis of examin nner stated.	owiedge, deat ation and/or in	h occurred vestigation	at the tim , in my or	ne, date an pinion, dea	d place, a th occurre	nd due to the o	cause(s) date and	and manner as s place, and due t	stated. o the cause(s	;)
	To th withir To th comp	Ψ	29b. Signature and title of certifier	01	,		29	c. License	number			∠9d. Date	signed (Month,	Day, Year)	
)			Mazar	1/40	af			D	283	65		10	129/01	5	
54	1-8+1		30. Name and address of person	2011	se of peath (Ite	m 23a) (Type,	Print)	, 51	Vel-	l	Hao	Zeen to	/29/04).	
	Sta	ate	31. Date filed (Month, Day, Year)	32.1	Registrar's Sign	ature					0	, ,			
- Top	Registr	rar	00131	1 2000	Bullen	A A		•							

DHMH 17 Rev 1/2001

ORIGINAL

Paul Matthew Servaty

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 36391

	1- For State Registrar	Cer	rtificate of Death		Reg.	ر ک ر . No.	0 000
Physician	Decedent's Name (First, Manne)				Day Year	3. Time of Death 1129 hrs	
ledical Examin	Iddi	Matthew Serva itution, give street and number)		or Location of Deat	October 29,	4c. County of Death	11291115
,	24220 Victory Lan	-	Clements			St. Mary's	
Funeral	5. Social Security Number	6. Sex 7. Age (In yrs. Ia					hplace (State or Foreign
Director	046-28-2703	1XM 2 F .70	Yrs. Months D	ays Hours Mir	11/20/1		untry) /_York
,	Usual Residence of Decede	nt			111/20/1	11,01	
ow any	10a State 10b. Cou		Town or Location				10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show	Maryland 10e. Street and Number	St. Mary's	Clemen [10f, Zip Code		100	. Citizen of What Cour	
th the Maryland 23a or 28a-f she gotified at once	0	T	101. 25 0000				•
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once		12. Was Decedent Ever in 1).	.S. 13. Was Decedent of I	20624 Hispanic Origin? (S	pecify Yes or No-	Jnited Stat	
death or item	11. Marital Status 1 Never Married 2	Armed Forces?	If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	White, etc.	
after o	3 Widowed 4	Divorced If Yes, Give Year or Dates:	1 Yes 2 X	No specify:		Specify: Whi	te
1215-0036 Id be filed within 72 hours after the letted Hygiene. nacked other than "natural" event, the Aedical Examine	15. Decedent's Education	(Specify only highest grade completed)	16a. Decedent's Usual Occup during most of working I			16b. Kind of Business/I	ndustry
36 iin 72 inan "	15. Decedent's Education Elementary/Secondary (0	College (1-4 or 5+)		N 1 .			
5-0036 led within 7 Hygiene, I other than	12 17. Father's Name (First, Mi	ddle, Last)	<u>Marine</u>	Mechanic 18.Mother's Nam	e (First, Middle, Ma	Marina aiden Surname)	
215 be file rital H.		. Servaty. Jr.		An	na Duch		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmatic event, the Medical injury or other transmatic event, the Medical	19a. Informant's Name/Rela	tionship (Type, Print)	19b. Mailing Address (St	reet and Number or	Rural Route Numb	er, City or Town, State	, Zip Code)
nore, MD 2 ages I and 2 shoul nt of Health and M t: If item 27 is in other traumatic.	Lula Mae Serv		24220 Victor	y Lane,		Maryland	
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr			crematory or other place)	cemetery,	Date	20c. Location - City or	Town, State
tim t. Pag tment rtant:	4 Donation 5 Other		nsfield-Echols			Charlotte	
Balt permit. Departs Import	21. Signature of Funeral Se	the he seem	22. Name and Addre	. В		l Funeral H	
Physician		e, or complications that caused the death	206 22955 Ho	LLVWOOD Rong, such as cardiac	oad. Leon or respiratory arres	nardtown . M st, shock, or heart	D 20650-027 Approximate Interval
/Medical	failure. List only one commediate Cause (Final dis	Independent of the state of the	d				Between Onset and Death
kaminer	or condition resulting in dea						
	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence o	w.				
	if any, leading to immediate cause. Enter Underlying Ca	ause					
	events resulting in death) L		of):				
		d					
760, ficate be en	UNPENDED IF FEMALE: 23b Was decedent pregnan	23c. If yes, outcome of preg	inancy			23d. Date of delivery	
687 ertifica ding p	23b. Was decedent pregnan past 12 months?	t in the 1 Live birth	2 Fetal death	3 Ectopic pregn	ancy	1	ay Year
Box 68's death certification attending ed for use as	past 12 months?	Unknown 9 Unknown	eath 5 Other (Specify)				
O. B.	Part II. Other significant co	onditions contributing to death but not r	esulting in the underlying caus	e given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
F. P.O. ires that the signed by a detached	AG T				1 Yes	2 No 3 Prob	ably 4 Unknown
ords, w requir	Completed				24a. Was an		topsy findings available ompletion of cause of
eco ne law te has	<u> </u>				perform	ned? death?	
tal Rec	 25. Was case referred to me 	edical	26.Pla	ace of Death (Check		, v	2 110
Vita hysicis this ce	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other Nursi	ng Home 5 R	esidence 6 🗸 Other	: Scene
J Of Jing Ph After t funeral	27. Manner of Death	28a. Date of Injury (Month, Day, Year) FOUND:	FOUND	njury at Work?	28d. Describe ho Subject shot	w injury occurred	
W = D 0 9	2 Accident	Investigation Oct 29, 2006	1129 hrs	Yes 2 ✔ No			
Division of Vital Records, pital or Attending Physician: The law require ours after death. reral Director: After this certificate has been stilled in by the funeral director, page 2 should be	1 Natural 5 2 Accident 3 Suicide 6 Homicide	Could not be	ome, farm, street, factory, offic	e building, etc.	or Town, Sta	ite)	ral Route Number, City
spi hou ner / fil		(openy) VVOods	Inc. death occurred at the time	date and place, an		ane, Clements, MD	
Division To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the	C (Check only	ng Physician: To the best of my knowled I Examiner: On the basis of examination a					
To wi	29b. Signature and title of c	and manner stated.	29c. Lice	nse number		29d. Date signed (Mor	nth, Day, Year)
	Jose Ca	el Jack nuo	0.0	C.M.E.		October 30, 2006	5
1011		erson who completed cause of death (Item	,				
8	Tasha Greenberg			t, Baltimore, M	D 21201		
Sta Registr	te 31. Date filed (Month, Day,)	(ear) 32 egistrar's Signate	Last.				

State of Maryland / Department of Health and Mental Hygien 36392 For State Registra Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Clark C. Snead 2006 7:45 Oct. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Avalon Manor Health Care Center Washington Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F 67 02/28/1939 **Director** <u>491-40-9283</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location il Hygiene. other than "natural", or Items 23a or 28a-f show vent, the Medical Examiner i sust be notified at 1 Yes 2 No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 701 Knightsbridge Drive, Apt. 2 US Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White ⋧ Specify: 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ring most of working Elementary/Secondary (0-12) College (1-4or 5+) Architectural Specifier Commercial t of Health and Mental Hyg If Item 27 is marked other or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ethel (nmn) Clark Henry L. Snead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 S. Mulberry Street, Hagerstown, MD 21740 Gordon A. Bartels / Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 10/28/2006 Smithsburg, MD 21. Signature of Euneral Service Licensee, 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician whent myounder Infancti fe mia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atten e detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wiknown Llitter Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 4NO funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After 1 1 Aatural s after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospital within 24 hours a To the Funeral C 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCT 27 2006 (Zetty MD D (8019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21740 HAKERS TOWN ATTLE TULLEY no 340 MILLST DH-15 31. Date filed (Month, Pay, Year) UCT 3 0 2006 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			1 - For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of H rtificate of I	lealth and M Death		ene () ()6	36393	
ı	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death			
	/Medic		Mildred May			October	29, 20	8:50 p M				
	Examiner 4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital						Location of Death Frederic	k	4c. County of Death Calvert			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year	If Under 24 Hrs.			9. Birtho	lace (State or Foreign	
ı	Director		183-14-04/6	^{1M 2} 84	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, June 22	,1922	Penn	sylvania	
	and	}	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				1	0d. Inside City Limits	
	Maryl -f sho	tor	Maryland Calvert Solomons								1 ☐ Yes 2 No	
	h the or 28a a notif	Director	10e. Street and Number		7010101	10f. Zip Code		10	g. Citizen of V	What Cour	ntry?	
	ath wi	raic	11740 Asbury Circ			20688			USA			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Eventinal must be notified at ODGE.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2500No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americ ck, White, V: Wh		
21215-0036	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation	ina 1	16b. Kind of B			
2	ithin 7 ie. ien "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most or work	mg				
2	iled w dygier her th		10 17. Father's Name (First, Middle, Last)		Но	memaker	18 Mother's Nam	e (First, Middle, N	Own I			
Maryland	d be f	To Be	Harry J.	Stor	ne		Edith	Ma		Frie	S	
ary	shoul ind Me is marl umati	۴	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Number,	City or Town,	State, Zip	Code)	
Ž	and 2 salth a n 27 li		Robert C. Snyder/S			Belle Ri						
altimore,	t of He if Iter		20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3 ☐ F		cemetery, crei	osition (Name of matory or other place Ld-Echols	(e)		20c. Location -			
<u>=</u>	it. Pa rtmen rtant: njury		' 4 □ Donation 5 □ Other (Specify)			2. Name and Addre		31/00 0	harlot	се па	TT, III	
Ba	Depa fmpo any is		21. Signature of Funeral Service Licens	THE	I	rinsfield .O. Box	d-Echols 128, Char			P.A. rylan		
L			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.				or respiratory arre	est,		Approximate Interval Between Onset and Death	
	Physician /Medical		mindediate Cause (Final disease or condition resulting in death) a. SEPSIS SYNDROWS Due to (or as a consequence of):							-		
	Examiner			b.								
-	ס ∺	lner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):								
	and I-trans	xam	that initiated events resulting in death) Last	Due to (or as a conse	quence of):							
8760,	cate be executed physician and s the burial-transit	dical Examiner		4	4							
Φ	tificate g phy as the											
Box	The law requires that the death certific the has been signed by the attending roage 2 should be detached for use as	by Physician/Me	23b. was decedent pregnant	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy	,			te of delive	*	
П	the at	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of death 9☐ Unknown Contributing to death but not resulting in the underlying cause given in Part I.				Month Day			Day Year	
P.0.	es that the death cer igned by the attendir be detached for use	/ Ph					en in Part I.	23e. Did tobacco use contribute to the cause of			ne cause of death?	
rds,	quires n sign ald be		MYO CARDIA	L INFARC	TION	1		1 □ Ye	s 2 🗆 No	3 Prob	ably 4 Unknown	
Vital Record	aw requir is been si 2 should	Completed	24a. Was an								psy findings available	
ž		Com			perform	utopsy prior to completion of cause of death?						
/ita	Physician: The lav r this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Oth		h (Check only on	9)			
o	두 등 교	. To	1 Yes 2 No	28a. Date of Injury	ER/Outpatie		4 - Indianing in	ome 5 Reside 28d. Describe ho			y)	
lon	nding Phy ath. r: After thi e funeral	atlor	1 XNatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □No					
Division	after des Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and City or Town, State)			d Number or Rural Route Number,)		
	To the Hospital or Attending, within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kr ner: On the basis of examinand manner stated.	nowledge, deal nation and/or in	th occurred at the timestigation, in my convestigation, in my convertigation.	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and mate and place,	anner as s and due to	tated. the cause(s)	
	To the To the To the Comple	Me	29b. Signature and title of certifier	,		29c. Licens	e number	25	9d. Date signe	d (Month,	Day, Year)	
)	,2		1 / ttu N	uch M.	0	403	70		10/3	30/0	6	
	10		30. Name and address of person who co				/210 D*	noo E 1	o se t = 1=	MD 0	0679	
100	A V		Peter L. Wisniew 31. Date filed (Month, Day, Year)	SKI IIU 32 Registrar's Sign		al Road #	JIU, Pri	nce Fred	erick,	MD 2	00/8	
	St: Regist	ate rar	OCT 3 1 200		K do	well.						

			For State Registrar	State of Marylan		artment of F			ntal H	giene Reg. No.		36	394
	19		1. Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·				2	Date of D	eath Day	Yea	3. Time	of Death
	Physicia /Medic		James William Swales								, 2006)7 P™
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location	of Death		4c.	County of De	eath	
	j.	1	45993 Great Mills		Lexing If Under 1 Year					St. Ma			
В	Funeral Director		5. Social Security Number 6. Sex	M 2DF	last birthday Yrs.	Months Days	Hours	Min.		ay, Year)		lirthplace (State Country)	or Foreign
*			215-64-7203 Usual Residence of Decedent	55			1		eptemb	er 5,1	.951 Ma1	ryrand	
	ylanc		10a. State 10b. County	10c. Cit	ty, Town or L	ocation						10d. Inside	
	e Ma	cto	Maryland St. Mary	r's L	exingt	on Park						1 🗆 Ye	s 2 🛣 No
	or 28	Director	10e. Street and Number	017 -		10f. Zip Code					zen of What	Country?	
	s 23a		45993 Great Mills	S Ct. 31/ B	10	206		ining (Consi	4. Van as b		JSA	nerican Indian.	
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 🛣 No	1.5.	Was Decedent of H If Yes, specify Cuba	an, Mexica	n, Puerto Ri	can, etc.)	10-	Black, W		
99	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify.	•			Specify:	Black	
Maryland 21215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dec	edent's Usual Occup	ation	et of working	,	16b. Ki	nd of Busines	ss/Industry	
2	ithin nen	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	, o					
2	fled w tygier her ti		11 17. Father's Name (First, Middle, Last)		Fork	lift Oper		er's Name (Eint Midd		struct	ion	
anc	od of	Be											
2	shoulk nd Me mark matic	င္	James Walter Milbu		19b. Mai	ing Address (Street		y Eli er or Rural I				, Zip Code)	
S S	s 1 end 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Examinar mast be rectified.		Agnes C. Swales/ W			3 Great M							20653
Je,	s 1 e of Heg Item		20a. Method of Disposition	20b. I	Place of Disp	osition (Name of amatory or other place	ce)	Dat		20c. Lc	cation - City	or Town, State	
E	Page ment c ant: If		1 🛣 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	-	Cemetery		Novem 9,200		Lec	nardto	own, MD	
Baltimore,	permit. Pages 1 end 2 Department of Health a Important: If Item 27 is eny injury or other trai		21. Signature of Funeral Service License		,) '	2. Name and Addre Mattingley-0 41590 Fenwi		ity er Fune	ral Ho	me, P.	Α.		
-	- A - A - 1		23a. Part . Enter the disease, or compli	cations that caused the dea							Lyland	Approxim	ate
	Physician		shook, or heart failure. List only or Immediate Cause (Final	Melas	tort	Puns	lak	(On	0 -			Interval B Onset and	Death
	/Medical	ý	disease or condition resulting in death)	Due to (or as a consec								17 100	CAINO
.34.	Examiner		Sequentially list conditions,										
	pe is	Iner	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):									
_	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):	nce of):							
8760,	be e	dical E											
687	ficate g phys	edic		J									
Вох	eath certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant 2	3 Ectopic pregnancy					23d. Date of delivery				
	death	sicia	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of €		Other (specify)	y 				Month	Day	Year
P.0.	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	9 Unknown										
	ires tha signed	by	Part II. Other significant conditions cor	ntributing to death but not re-	sulting in the	underlying cause giv				tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown			
Orc	w requir been si should I	eted					_						
3ec	e law has t	Completed							24a. Wa	s an opsy formed?	24b. Were prior death	autopsy finding to completion of	s available cause of
a	n: Th ficate		65 W						1 Yes	2 4 No		es 2 No	
Ξ	Physicien: this certificand in this certificand in the central director.	o Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2 ☐]ER/Outpatie	ent 3 DOA Oth	105	e of Death (6 DOth /6	4.)	
of	Phy sr this sral d	J: To	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Injui	7				6 Other (S	рөспу)	
ion	Attending ir death. ector: After by the fune	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		rk? ∣Yes 2.[]No					
Division of Vital Records,	l or Attanding Physicien: The latter death. Director: After this certificate he in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h	nome, farm, s	street, factory, office		28	If. Location	(Street an	d Number or	Rural Route Nu	ım <i>ber</i> ,
Ö	itel or irs afte rel Dir led in	Cer										S. La P. C. S. S. S. S. S. S. S. S. S. S. S. S. S.	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier : Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, dea ation and/or	feath occurred at the time, date and place, and due to the or investigation, in my opinion, death occurred at the time,				e cause(s) e, date and	e cause(s) and manner as stated. , date and place, and due to the cause(s)		
0	To the To the To the Comp	ž	29b. Signature and title of certifier			29c. Licens					- /	onth, Day, Year)	
)			16 Man			0 20	086				11/06	12006	
			30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type	Print)	ONAP	DTOW	N, M	0 20	650		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature								
1	Regist	rar	NOV 0 6 2006	K A									
-	HMH 17 Rev 1/2	2001		JU AN									

ORIGINAL

			State o	of Maryland / Depa	artment of Health		ene 006 36395
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) DAVID Education 4a. Facility Name (If not institution, give street and number 1)	Shepley	4b. City, Town, or Location	2. Date of Death Month	
*	Examin	er	Homewood	inbery	Williamsp		Washington
1, 11, 3	Funeral Director		5. Social Security Number 6. Sex 1 A - O9 - 1 A - 1 A M 2 F Usual Residence of Decedent	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year If Under Months Days Hours	Min. 8. Date of Birth (Month, Day, Dec. 10,	year) 9. Birthplace (State or Foreign County) Maryland
	Maryland a-f show	ctor	10a. State 10b. County Maryland Washingt	10c. City, Town or Lo	Williamspor	t	10d. Inside City Limits 1 ☐ Yes 2 ∰No
	with the	i Director	10e. Street and Number 16505 Virginia Avenue		10f. Zip Code 2179.		g. Citizen of What Country? USA
980	n 72 hours after death with the Maryland "natural", or freme 23a or 28a-f show coreal Examinan must be notified at	by Funerai		2 No	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2 No Specif		14. Race - American Indian, Black, White, etc. Specify: white
21215-0036	d within 72 giene. ir than "na! Ine Medic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (12 0	(Give life.	dent's Usual Occupation kind of work done during mo DO NOT use retired) Lesman	ost of working	6b. Kind of Business/Industry hardware
Maryland	chould be filed and Mental Hygic marked other matic svent, II	To Be C	17. Father's Name (First, Middle, Last) Harry Leander Shepley			her's Name <i>(First, Middle, M</i> arrie May Sny	
Mary	a a a		19a. Informant's Name/Relationship (Type, Print) Douglas E. Shepley - sor		•		City or Town, State, Zip Code) Pennsylvania 17268
	of Heal		20a. Method of Disposition 12 Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Dispo cemetery, crea	osition (Name of matory or other place)	Date 2	Oc. Location City or Town, State lear Spring, Maryland
Baltimore,	permit. Page Department i Important: If any injury or pnce.		4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee		2. Name and Address of Fac	minnich	FUNERAL HOME town, Md. 21740
	Physician // Medical Examiner white private it augment of the private	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence of): (or as a consequence of):	r cadio	prascula .	Interval Between Onset and Death Years
O. Box 6	at the death certific by the attending pi tached for use as it	Physician/Me	in the past 12 months?	nant at time of death 5[□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P	ires that signed b	þ	Part II. Other significant conditions contributing to d	leath but not resulting in the u	inderlying cause given in Par	t I. 23e. Did tob.	accoluse contribute to the cause of death?
Records,	The law requires that sate has been signed b page 2 should be deta	completed	prostate care	n 24b. Were autopsy findings available prior to completion of cause of death?			
Vital	ician: certific rector.	Bec	25. Was case referred to medical examiner?		Other	ce of Death Check only one	
o	fter inel	ation: To	27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatier of Injury oth, Day Year) 28b. Time of Injury	III 3L DOA	Nursing Home 5 Resider 28d. Describe hor No	
Division	P S S S	Certification:	3 Suicide 6 Could not be 28e. Place	e of Injury - At home, farm, st ling, etc. (Specify)	reet, factory, office	28f. Location (Str City or Town,	eet and Number or Rural Route Number, State)
	Hos Fur Jely	edical (29a. Certifier (Check only one) Certifying Physician: To the 2 Medical Examiner: On the and man	e best of my knowledge, deat basis of examination and/or in oner stated.	th occurred at the time, date a evestigation, in my opinion, de	and place, and due to the ca eath occurred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
\	To the within 2 To the complet	Σ	29b. Signature and title of confus		29c. License numbe		d. Date signed (Month, Day, Year)
,			30. Nac a dd se of pers o completed	of death (Item 23a) (Type,	Print)	1.1	Vovanter 1 2000 Loun MD 21742
21	√-/6+ Sta Registi		Date fil work (12 2006) 32. F	Registrar's Signature	tiric Nhea South	ne Hagars	four MD 21742

State of Maryland / Department of Health and Mental Hygiene 2 () () 5 1 - For State Registra Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) October **Physician** 2g 2006 12:14 P M Robert Hackworth Swope /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death **Examiner** Anne Arundel Annapolis 966 Sawgrass Way 8. Date of Birth (Month, Day, Year) 02/21/1938 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Maryland Director 68 219-36-8561 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Marvland | Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 United States 966 Sawgrass Way within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Spacecraft Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H Pages 1 and 2 should be Helen H. Hackworth Robert L. Swope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 201 Silger Road, New Freedom, Pennsylvania 17349 Gary H. Swope/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State permit. Page Depertment o Important: If any Injury or once. 10/30/2006 Edgewater, Maryland Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Puner Service Licensee 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -SMal Ung cancer **Physician** CCI months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical ettending pl 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificete hes b lirector, page 2 s autopsy 1 ☐ Yes Division of Vital : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Injury at 28d. Describe how injury occurred 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: Natural 5 Pending investigation 1 Yes 2 No death. **Z** ☐ Accident ector: , by the f 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide within 24 hours after de To the Funerel Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Carritying Physician: To the best of my knowledge, death orguned at the time, date and plane, and due to the causals) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Wenn MO October 29, 2006 152830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Jeanine Werner, 900 Bestgate Road #300, Annapolis, Maryland 21401

32 Aegistrar's Signature

31. Date filed (Month, Day, Year) OCT 3 0 2006

State of Maryland / Department of Health and Mental Hygien [] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 4:55 P Blanche Schmitt November 4, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Caroline Ruxton Health of Denton Denton If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2ЫF Months Yrs. June 6, Director 220-01-8066 101 Marylana Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show other treumstic event, the Medical Examiner must be notified at N☐Yes 2☐No Director Maryland Caroline Denton the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filled within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other then "--- eny injury or other treum=""--- one yinjury or other treum="--- one yinjury or other treum="---- one yinjury or other treum="---- one yinjury or other treum="---- one yinjury or other treum="----- on ò 21629 United States of America 211 South Eighth Street Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Caucasian 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 HS Grad Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Edward Pollard Flonnie Hynson ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31307 Dukes Bridge Rd, Cordova, Maryland 21625 Jeanette Swartz Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/8/2006 Ridgely, Maryland ¹ 4 □ Donation 5 □ Other (Specify) Ridgely Cemetery 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, 21. Signature of Funeral Service License ando LOOK Denton, Maryland 21629 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final **Physician** Dheumonea disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause ol death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ate has page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11/6/06 MI D0047534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 920 Market Street, Denton, Maryland 21629 Wafik Zaki, M.D., 2006 32. Regi 31. Date filed (Month, Day, Year) ar's Signature State 8

Registrar

State of Maryland / Department of Health and Mental Hygiene ? 36398 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** W. Reba Salmons October 30, 2006 4:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Denton Caroline Nursing Home Caroline If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Months 215-20-1373 Jan. Director 80 23. 1926 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 No Director Federalsburg MDCaroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 303 Morris Avenue or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Independent: If Item 27 is marked other than "naturar, or Items 23a emp injury or other traumatic event, the Medical Examples PARTMENT. United States Completed by Funeral 21632 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Waldis Minnie Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Morris Avenue, Federalsburg, MD 21632 <u>Jack Salmons, Sr./Spouse</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 11/04/06 Federalsburg, MD 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee Esten 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 12 hermer's **Physician** 10 4RS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Physician/Medical Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for Month in the past 12 months? 1 ☐ Yes 2 🔼 No Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ director, page 2 should be 1 ☐ Yes 2 🗀 You 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 vursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Medical Certification: To this 27. Manner of Death 1 Anatural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely within 2 To the 29d. Date signed (Month, Day, Year) D 35284 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cuashington St Easton mo 21601 Allow MD 219 32. Registrar's Signature State Registrar

F	Physicia	an	For State Registrar 1. Decedent's Name (First, Middle		÷ ···	Certifica	te of L	Death		Date of Dea Month	Day	Year	3 6 3 9	Death
	/Medic Examin	-	Edgar U. Sta: 4a. Facility Name (If not institution	n, give street and number				Location of		ctober	4c. 0	County of Dea	11:00) AM
	Funeral Director		Union Hospital 5. Social Security Number 217-01-7575		ounty Age (In yrs. last 87		r 1 Year Days	If Under 2 Hours	Min.	Date of Birtl (Month, Day	h v, Year)	C	thplace (State or ountry) ryland	Foreign
	he Maryland 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Cec 10e. Street and Number	i 1	10c. City, To		p Code				10- Cisi-	en of What C	10d. Inside City 1 X Yes	
920	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or litems 23a or 28a-f show marked other than "natural Exa ultier fruint be notified at	by Funeral	150 East Main S 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 [XYes 2]	nt Ever in U.S.	13. Was Dece	21921 edent of Hi ecify Cuba		in? (Specify Puerto Rica	Yes or No-	Unit	ed Sta 4. Race - Am Black, Whi	tes erican Indian,	
nd 21215-003	e filed within 72 ho al Hyglene. other than "natur vent, the Modical	3e Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle,	College (1-4d		6a. Decedent's Us (Give kind of w life. DO NOT She	ork done o	during most		irst, Middle,	Law	d of Business Enforc Sumame)		
Maryland	2 should be and Mental is the marked o	To B	William H. Sta	hip (Type, Print)		19b. Mailing Addres		and Number		oute Numbe				0.1
altimore, M	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic poce.		Angelia Burnett 20a. Method of Disposition 1 ♥ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S 21. Signatural Junes Learvice	3 □Removal from Sta	20b. Place ceme	e of Disposition (Na etery, crematory or con Cemet	ame of other place	Ne) Ne	ovembe	er 06	20c. Loc Elkt	Maryl cation - City of con, Ma 1 Home	Town, State)1
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that cause only one cause on each	n line.		de of dyin	g, such as c	cardiac or re			ast, M	Aryland2 Approximate Interval Betwonset and D When are	veen
8760,	Attending Physician: The law requires that the death certificate be executed refeath. Totath. Sector: After this certificate has been signed by the attending physicien and properties of the funeral director, page 2 should be detached for use as the burial-transit and properties of the funeral director, page 2 should be detached for use as the burial-transit.	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>Car</u> Due to (or	as a consequent as a consequent as a consequent	Colon ce of):							unkna	12) 4
P.O. Box 6	the death certific y the attending pl ched for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 ☐ Fetal de t at time of death	ath 3 Ectopic		,			2	3d. Date of de Month		'ear
	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant condition	ons contributing to deat	h but not resultir	ng in the underlying	cause giv	en in Part I.				se contribute I	o the cause of de	eath? Inknown
al Records,	n: The law re licate has bee r, page 2 sho	Completed								1 Tes	rmed? 2 No	24b. Were a prior to death?		available ause of
Division of Vital	nding Physician: The lav ith: :: After this certificate has e funeral director, page 2	ation: To Be	25. Was case referred to medica examiner? 1	Hospital: 1 ☑ Inp 28a. Date of (Month,		VOutpatient 3 [28c. Injur Wor	er: 4 🗆 Nur	rsing Home	5 Residue. 5 Residue.	dence 6	Other (Sp	ecify)	
Divis	in the second	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of building	etc. (Specify)	a, farm, street, facto			28f	City or Tov	vn, State)		Ru <i>ral Route N</i> uml	ber,
	To the Hospital within 24 hours a To the Funeral I completely filled	Aedical	(Check only 2 Medical one)	ng Physician: To the be Exeminer: On the basi and manner	s of examination stated.	n and/or investigation	n, in my o	pinion, deat	th occurred	at the time,	date and	place, and du	e to the cause(s))
)	o T with	N	30. Name and address of person 31. Date filed (Month, Day, Year, NOV 0.2	Tachder	s mo		DOOG	2332	2_		290. Date	16/3d/	106.	
1)+IVA		30. Name and address of person S - O - O - O - O - O - O - O - O - O -	who completed cause	of death (Item 23	3a) (Type, Print)	it 8	B, 6	Elki	n Mi) 2/	92/		
	Sta	rar	NOV 02	2006	K	Copelas								

			1 - State of M	aryland / Depa <i>Cei</i>		of Health of Death		ental F	lygie Reg.	/ 111	16	36400
	Physici /Medic	~	1. Decedent's Name (First, Middle, Last) Iladawn (NMN)		Swart			2. Date of Month Oct		Day 2006	Year	3. Time of Death 8:26 A M
	Examin		4a. Facility Name (If not institution, give street and number, 4255 Harvey Road	_	H	wn, or Location untingto	own		,	4c. County o	f Death	
	Funeral Director		5. Social Security Number 026-24-2445 Usual Residence of Decedent	ge (In yrs. last birthday) 75 Yrs.	Months D	Year If Under Days Hours	Min.	8. Date of Month, Apr	Birth Bay, Ya	1932		ace (State or Foreign Cord, N.H.
	h the Maryland rr 28a-f show rnctiffed at	Director	10a. State 10b. County MD Calvert 10e. Street and Number	10c. City, Town or Lo		ode			10g.	Citizen of W		0d. Inside City Limits 1 ☐ Yes 2 ☐ No try?
9036	be filed within 72 hours after death with the Maryland the byglane. Hyglane byglane of other than "natural", or iteme 23a or 28a-f show event, the Madical Examinar most ke notified at	by Funerai	4255 Harvey Road 11. Marital Status 12. Was Decedent Armed Forces 1 □ Yes 20 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces 1 □ Yes 20 12. Yes 20 12. Yes 20 12. Yes 20 12. Yes 20 12. Yes 20 12. Yes 20 12. Yes 20 13. Yes 20 14. Yes 20 15. Yes 20 16. Yes	? č No		20639 t of Hispanic Or Cuban, Mexica		cify Yes or lican, etc.)	No-	14. Race	JSA - America White, o	etc.
Baltimore, Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or	(Give	DO NOT use i	done during mos retired) Operate	or		ŗ	reamste	ers I	•
yland		To Be	17. Father's Name (First, Middle, Last) Michael	Swart		A1	ic e			den Sumame	Aust	
e, Mai	1 and 2 Health a Bm 27 le ther tra		19a. Informant's Name/Relationship (Type, Print) Patricia Osbourn (friend 20a. Method of Disposition	40000	Harve	ireet and Numb y Road of	Hunt	ingto	wn,		0639	
Itimor	permit. Pages Department of I Importent: If It eny Injury or o		1	Ft. Linc	oln Cer	metery	Oct. 20	06	B	rentwo	od. I	WID.
Ba	Depa Impo		Gary J. Goff 23a Pan Pinter the disease, or explications that cause	8	125 So	uthern	Maryl:	and E	lvd	. Owi		
8760,	Physician and /Medical Examiner tues of partial transit tues private the private transit for the priva	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):	TRUC	1106	PULI	M ON/	2 RY	Dise	45E	Interval Between Onset and Death
.O. Box 6	thet the death certificated by the ettending plant detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregr Other (specin				-	23d. Date Mont		ry Day Year
rds, P	law requires thet the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death t	out not resulting in the u	nderlying caus	e given in Part i	l.					e cause of death?
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2 2 2	Physician: this certific al director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpati	ent 2 ER/Outpatien	it 3□ DOA	O#	e of Death	1	-	e 6 □Other	(Specify)
Division of	ding h. After funer	Certification:	27. Manney of Death 1 Whatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	y Year) Injury	М	Injury at Work? 1 Yes 2	28]No	Bd. Descrit	e how i	njury occurre	i	
O N	e Hospital or Atten 1.24 hours after deat E Funeral Director: letely filled in by the		determined 286. Place of In	jury - At home, farm, str ic. (Specify)				City or	Town, S	tate)		Route Number.
	To the Hos within 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner sill. 29b. Signature and title of certifier	of examination and/or in	vestigation, in	my opinion, dea	ath occurred	d at the tim	e, date	and place, an	d due to	the cause(s)
)			30. Name and address of person who completed cause of	Phpic death (Item 23a) Type.) 194	2/			tober		
	6		Anwar T. Munshi, M.D.	110 Hospit	al Rd.	, Suite	303,	Pri	ice	Freder	ick,	MD 20678
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regist 0CT 3 0 2006	Wishes H.	Speed							

			For Stata Registrar			of Maryla		artment of F			Reg.	200	6	36401
	Physici	an	Decedent's Name Management							2. Date of Month			Year	3. Time of Death
	/Medic	al	Mary 4a. Facility Name (fi	Elaine	Sin			4b. City, Town, o	r Location of	Nov.		4c. County 0	of Death	11:40 A ^M
-	Examir	er		land-San				0ak1					rett	
1	Funeral		5. Social Security N	lumber 6.	Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of (Month,	Birth Day, Ye			lace (State or Foreign
100	Director		213-44-2	.190	1□M 2\\ F	61	Yrs.	Working Days	110010	6/14/	1945	5		y1and
	land II		Usual Residence of 10a. State	10b. County		10c. C	City, Town or Le	ocation					1	0d. Inside City Limits
	Mary -1 •h	to	MD	Garr	ett		0 a k1	and						1 ☐ Yes 2 🛣 No
	or 28g	Director	10e. Street and Nur	mber				10f. Zip Code			10g.	Citizen of W	hat Cour	ntry?
	ath wi	rai	4368 Oak	land-San	Ť				550			USA		
21215-0036	s within 72 hours after death with the Maryland Jiene. I than "natural", or Items 23a or 28a-1 ehow Itte Medical Examinat must be rooffled at	by Funerai	11. Marital Status 1 Never Marri 3 Widowed	ied 2 ∑ Marned 4 □ Divorced	12. Was Dec Armed For 1 Yes If Yes, Gi Year or D	2 X No ive	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No		n? (Specify Yes or Puerto Rican, etc.)	No-		c, White,	ean Indian, etc. nite
5-0	72 ho	Completed	(Spec	15. Decedent's E	ducation rade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most o	of working	16b	, Kind of Bu	siness/In	dustry
121	within iene.	mpl	Elementary/Seco			1-4or 5+)				•	F	lamant		School
d 2	H Hyg		12 17. Father's Name	(First, Middle, Las	:t)		1ea	cher's Ai		s Name (First, Mid				3011001
lan	0 0 0 0	To Be	Robert		Wi	nters			Mary	Cath			21ke	
Maryland	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Maili	ing Address (Street	and Number	or Rural Route Nu	mber, Ci	ty or Town, S	State, Zip	Code)
≥, ≤	Health tem 27			A. Sines	/ Husba			Oakland-						21550
Baltimore,	00-		4 Donation	☐Cremation 3 l 5 ☐Other (Spec	ify)		aylor S	osition (Name of matory or other place ines Ceme	etery		08	. Location - 0 akland	, MD	own, State
Balt	permit. Pag Department Important: I eny injury o		21. Signal Tre of Fu	ineral Service Lice	CM			2. Name and Addre tewart Fu				econd , MD	St. 2155	50
			23a. Part1. Enter t shock, or hea	the disease, or con art failure. List onl	mplications that y one cause on	caused the de each line.	ath. Do not en	ter the mode of dyir	ng, such as ca	ardiac or respirator	y arrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause disease or condition resulting in death)	(Final on	a. Me	tastati	c Colo	n Cancer						9 Months
1	/Medical Examiner		rossiting in country	1	Due to	(or as a conse	equence of):							
		ler	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nditions, nmediate	b. Due to	(or as a conse	equence of):							
	sician and burial-transit	Examiner	that initiated events	S	c									
30,	ate be exe nysician au he burial-t		resulting in death)	Last	Due to	(or as a conse	equence of):							
8760,	physic physic the b	dica		•	d									
9 X	eath certific attending p I for use as	/Me	IF FEMALE:		23c. If yes, ou	stcome of preg	nancy					23d. Date	of delive	20/
P.O. Box	Physician: The law requires that the death certificate be executed in this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was deceden in the past 12 1 ☐ Yes 2 ∫ 9 ☐ Unknown	months?	1 Live	birth 2□Fe nant at time of	tal death 3	□Ectopic pregnancy □ Other (specify)	<u> </u>		_	Mon		Day Year
	es that igned to be deta	by Pi	Part II. Other signif			death but not re	esulting in the t	underlying cause giv	en in Part I.	23e. D	id tobaco	co use contri	ibute to ti	ne cause of death?
ord	v raquire baan sig should b		High	Blood P	ressure					_ 1	☐ Yes	2 No	3 Prob	ably 4 Unknown
Records,	e law re has be je 2 sho	Completed	Asth	ma						24a. W	utopsy	p	rior to co	psy findings available mpletion of cause of
<u>~</u>	ysician: The is certificate hidirector, page	S			_					1 ☐ Ye	erformed s 2		eath?	2 No
Vital	iiclan: Th certificate rector, pag	Be	25. Was case refer examiner?		Hospital:			nt 30 DOA Oth	0.5	of Death (Check on				
ō	Physic rithis oral di	. To	1 Yes 2		28a. Date	of Injury	ER/Outpatie	all 30 DOV	4 🗆 Nurs	sing Home 5 A		6 UOthe		y)
Division	Attending Phy r death. ector: After this y the funeral or the funeral control of the funeral control or the funera	Certification:	1 ☐ Natural 2 ☐ Accident	5 Pending investigati		nth, Day Year)	Injury		k? Yes 2∐N	0				
Vis	Attendi	tifica	3 Suicide	6 Could not determine	d 288. Plac	e of Injury - At ling, etc. (Spe	home, farm, si	reet, factory, office			n (Stree Town, Si		or Aura	I Route Number,
Ö	ital or A irs after rai Direc led in by	Cer			li .									
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)	← Certifying F 2 Medical Ex	aminer: On the I	e best of my k basis of exami nner stated.	nowledge, dea nation and/or in	th occurred at the tire envestigation, in my d	me, date and epinion, death	place, and due to a occurred at the time	the cause ne, date	e(s) and mar and place, a	nner as s ind due to	tated. o the cause(s)
	Vith To t	Σ	29b. Signature and	I title of certifier				29c. Licens	e number		29d.	Date signed	(Month,	Day, Year)
				195	mr				D15333			11/3/	06	
			30. Name and add	*				Print) th St., O	akland	. Marvle	nd '	21550		
	P car	ate	31. Date filed (Mon	oth Day Yearl	32	Regietrar's Sig	nature			, , 101				
<i>3</i> 2	Regist			NOV -	8 2006	1 Jose	B.	Granth "						
Uh	IMH 17 Rev 1/2	COD												

ORIGINAL

			For State	State of Ma	ryland /	-			lental Hyg	iene	<i>p</i>	00100
			Registrar 1. Decedent's Name (First, Middle,	Lacti		Cen	ificate of L	Jeatn	2. Date of Deat	eg. No. U U	D	36402
	Physicia		EILEEN		KER	2			Month / 2	Day / Ye	ear	3. Time of Death 1045 PM
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location of Death	10/	4c. County of I	لمتسلم	
				anor			Ball	imore	_	E	Baltim	ore
	Funeral Director		214-24-8254	6. Sex 7. Age	(In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 15		Birthpla Countr M	ice (State or Foreign y) aryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loca	ation				100	d. Inside City Limits
	Maryl f sho	to		altimore	,,			Baltimore				1 ☐ Yes 2 No
	r 28a	irec	10e. Street and Number	ittillore			10f. Zip Code	Daitimore	1	0g. Citizen of Wha	it Countr	y?
	th with	al D	2095 R	ockrose Avenue				21211		J	J.S.A.	
	tems et a	ner	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black.	America White, et	
2	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "natural", or Items 23e or 28a-f show umatic event, it a Modical Exerting matter mailied at	by Funeral Director	1 Never Married 2 Marrie 3 XWidowed 4 Divorced	ld 1 ☐ Yes 2 M N If Yes, Give Year or Dates:	0	10	☐ Yes 2 No	Specify:		Specify:		White
2	2 hou	ted	15. Decedent	s Education	16	a. Decede	nt's Usual Occupa	ntion		16b. Kind of Busin		
, ,	ithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. Do	O NOT use retired;		ang			
7	led w tygien her th		12	0			Hor	memaker			Home	2
ב	2 should be filed with and Mental Hygiene. Is marked other that aumatic event, Itel	Be c	17. Father's Name (First, Middle, L	Unknown				18. Mother's Name		nknown		
2	should nd Me mark matin	٦	19a. Informant's Name/Relationsh	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	1 19	9b. Mailing	Address (Street a	and Number or Run			te. Zip C	Code)
M	1 and 2 Health a tem 27 is		James McKenzie -	Funeral Director				Main Street,				,
ט כ	of He of He fitem r oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Demoval from State	20b. Place cemet	of Disposit	tion (Name of atory or other place	-1	Date :	20c. Location - Cit	y or Tow	m, State
	. Pages Iment of It Iant: If ite		`4 Donation 5 Other (Sp	ecify)	St. Jo		Catholic Cer	netery	07, 2006	Midlan		ryland
מס	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Pratural; or Items 23a or 28a-f show Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Modical Exemples mail be notified at once.		21. Signature of Funeral Service L	icensee_		22.	Name and Addres	s of Facility Eichhorn-Mc East Main St	Kenzie Fun	eral Home P	P.A.	
			23a. Pan 1. Enter the disease, or on shook, or heart failure. List of	complications that caused nly one cause on each lin	the death. Do	o not enter	the mode of dying	g, such as cardiac	or respiratory arre	est,	1	Approximate nterval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a Athor	osch	lerot	ie Ca	diols	sculer	Diseas	e (Onset and Death
	Examiner		Sequentially list conditions.	Due to (or as a	•							
	cuted od ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequenc	e of):						
ָב ב	cate be executed physician and the burial-transit	I Ex	resulting in death) Last	Due to (or as a	consequence	e of):						•
00/00		dlcal		d								
40	death certific a attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Date o	f deliven	,
	ires that the death cer signed by the attendir d be detached for use	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			ectopic pregnancy Other (specify)			Month		Day Year
Ļ	s that the	by Ph	Part II. Other significant condition	s contributing to death bu	t not resulting	g in the und	terlying cause give	en in Part I.	23e. Did tob	acco use contribu	te to the	cause of death?
7	w requires been sig should be								1 □ Ye	s 2□No 3[□ Probat	bly 4 Donknown
טטטר	he law re e has be ige 2 sho	ompleted							24a. Was ar autops perform	prior deal	r to com th?	sy findings available pletion of cause of
2	ysician: The lis certificate hadirector, page	e C	25. Was case referred to medical					26. Place of Deat		1 1 1 1 1 1 1 1 1 1	Yes 2	No
>	Physici this cer al direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/C	Outpatient	3□ DOA Othe			nce 6 Other (Specify)	
5	or Attending Phater death. Director: After thin by the funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b	. Time ol Injury	28c. Injury Work	at		w injury occurred		
2	ttendi death.	icatl	2 Accident investigation inve	ation of he	At h	f		res 2 □No	006 1			
2	tal or Airs after of al Direct of in by	Certification:	4 ☐ Homicide determin	28e. Place of Inju building, etc	ry - At nome, . (Specify)	ram, stree	et, factory, office		City or Town	reet and Number o , State)	or Hurai i	Houte Number,
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours atter death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier Check only one) Certifying	Physician: To the best of xaminer: On the basis of and manner stat	examination a	lge, death o and/or inve	occurred at the timestigation, in my op	e, date and place, pinion, death occur	and due to the cared at the time, da	use(s) and manne ate and place, and	er as stat due to t	ted. he cause(s)
	with To t	M	29b. Signature and title of certifier	R	ı,	M-D.	29c. License	74-0 S	25	9d. Date signed (A	fonth, Da	ay, Year)
	1	0	30. Name and address of person v	the completed cause of de	ath (Item 23a	a) (Type, Pr	ENTOW	st. B	altim	ae M!)21	1201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	· A.						
		1 Y	1404 _		HOLD ALP	100						

			1 - For State Registrar	State of Ma		ertificate of		nd Mental Hy	giene Reg. No 2 0 0 5	36403
	Physicia /Medic		Decedent's Name (First, Middle, Last) Robert	Paul	Sumpt	er		2. Date of Dep Month Octobe	Day Year	
1	Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, o		Death	4c. County of Dea	
	F		Doctors Hospital 5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday	Lanham	If Under 24	Hrs. 8. Date of Birt		Georges
	Funeral Director		214-58-3692 Usual Residence of Decedent	7 _	54 Yrs.	Months Days		Min. Apr 13	1952 Was	inthplace (State or Foreign Country) Shington, DC
	yland		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Ba-f e	ctor	MD Prince Ge	eorges	Greenbe	1t				1 □ Yes 2XXNo
	with th	Dire	10e. Street and Number			10f. Zip Code	70		10g. Citizen of What C	Country?
	eath	erai	44 C. Ridge Road	12. Was Decedent B	ever in U.S. 13	207		n? (Specify Yes or No	USA 14. Race - Am	perican Indian
9	72 hours after death with the Maryland Insture!; or Items 23s or 28s-f ehow Ites! Examine must be molified a	by Funeral Director	1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 XYes 2 □ N	lo	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, F Specify:	n? (Specify Yes or No- Puerto Rican, etc.)		
9	urel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						
21215-0036	in 72 in 72 in mat	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Giv	edent's Usual Occup e kind of work done o DO NOT use retired	during most of	f working	16b. Kind of Busines	s/Industry
212	d within glene. or than "	mo:	Elementary/Secondary (0-12)	College (1-4or 5		sman			Contracto	r Supply
pu	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Sumame)	
yla	i Men marke	ို	Denzil Sumpter	O-1-0	401.44	F		n Barham	0. 7 0.	7.0.1
Maryland	and 2 st eatth and m 27 is r		19a. Informant's Name/Relationship (Ty) Christine Sumpter					reenbelt,	er, City or Town, State,	Zip Code)
re,	item		20a. Method of Disposition			position (Name of ematory or other place		Date Date	20c. Location - City o	or Town, State
Ē	Page ment c ant: If ury or		1 ☐ Burial 2 【XCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Metro Cr		ı	-26-2006	Baltimore,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-1 ehow apply injury or other traumatic event, the Marical Examination at a profiled at once.		21. Signature of Foney Service Licent	е		22. Name and Addre Hardesty	ss of Facility Funer	al Home, F	.A.	2105/
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused	the death. Do not e				rills, MD	21054 Approximate Interval Between
8760,	Physician /Medical Examiner bubsicion and bubsicion and ithe pritial-transit	Icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of):	ttmew'		=		Onset and Death
P.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	/		23d. Date of d	elivery Day Year
	w requires thet s been signed b should be deta	ρχ	Part II. Other significant conditions con	tributing to death be	ut not resulting in the	underlying cause giv	en in Part I.		obacco use contribute Yes 2 □ No 3 □ F	
of Vital Records,	The la	Completed	Corners	Artery	Rym	·		24a. Was autop perio 1 □ Yes	prior to rmed? / prior to death?	
/ita	Physicien: The this certificate har ral director, page	Be	25. Was case referred to medical examiner?	/	,			Death Check only o	ne)	
on of	ing After uner	tion: To	1 Pes 2 No 27. Manner of Death 1 Datural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatie 28a. Date of Injud (Month, Day		of 28c. Injur	4 🗆 (40) 5)	28d. Describe I	dence 6 Other (Sp now injury occurred	ecify)
Division	P Sign	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At home, farm, s	street, factory, office		28f. Location (S City or Tox	Street and Number or f vn, State)	Rural Route Number,
	To the Hospitel or At within 24 hours after or To the Funaral Direct completely filled in by	edical	(Check only 2 Medical Examile one)	ner: On the basis of and manner sta	examination and/or	ath occurred at the tri investigation, in my o	ne, data and p prinion, death	plane, and due to the occurred at the time,	causu(s) and manner (date and place, and du	us stated ue to the cause(s)
	Mithi To t	Σ	29b. Signature and title of certifier	n n		29c. Licens			29d. Date signed (Mor	
7			17)	1110		MAD	605	75	10/26	106
	31		30. Name and address of person are co	mpleted cause of d	eath (Item 23a) (Type MAN SC	9, Print) = # 35/	LAV	45 Re/ms	40707	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 7 20		ar's Signature	book				

Sumpter Robert Paul

	1-	For State Registrar	end Ite	nStatea of the	(anyland		11710 rtificat	i/O6d e of L	Hal th a Death	and M		giene Noc	0.0	_	0.61	0.1
		ecedent's Name (Fi	rst, Middle, Last)								2. Date of Dea		. U U	ear ear	G) Time of	Death +
Physician /Medical		erdeen	Ţ	Vilson		S	hoop				October	28,	200	6	4:10	РМ
Examiner	4a.	acility Name (If not		treet and numbe	7)				Location of	of Death			County of			
		1 Antieta		7.4	Age (In yrs. I	ast hinthday)	Hag If Under	erst 1 Year	OWN If Under:	24 Hrs.	8. Date of Birtl		lashi		ace (State o	r Foreign
Funeral Director	21	9-12-0206	5 ¹ X	M 2□F	82	Yrs.	Months	Days	Hours	Min.	Month, Day	Yearl		Coun	land	or r-oreign
than "natural, or items 23s or 28s-f show , is Medical Examination invariant by modified at modified by Empired Director			o. County		10c. City	r, Town or Lo	cation							10	Od. Inside C	ity Limits
ifed ifed	1	I OI	Washingt	on	На	gersto	wn								1 🗌 Yes	2₹ No
or 28	10e	Street and Number					10f. Zip	Code				10g. Citiz	en of Wha	at Coun	try?	_
23a		811 Antie						742					S.A.			
If health and Mental hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, its Medical Exactly actional be notified at To Be Completed by Funeral Director	11.	Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐	2 ∏ Married	2. Was Deceder Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	? ₹ No		Was Deced If Yes, spec 1 Yes :	offy Cuba	spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)		Specify:	America White, 6	etc.	
atura cat E			Decedent's Educ	ation		16a. Dece					1	16b. Kin	d of Busin			
ygiene. Ner than "natura" 1, Ive Medical Completed	E	(Specify o	nly highest grade y (0-12)	Completed) College (1-4o	r 5+)	(Give life.	kind of wor DO NOT us	rk done d se retired,	lu <i>ring m</i> osi }	t of workir	ng .					
Con						Sawy	er					Man	ufac	tur	ing	
even Be	17.	Father's Name (Firs		~*							(First, Middle,		Sumame)			
and Mental Hygiene. Is marked other than aumatic event, Ite M. To Be Comp		harles Fi		•		10h Maili	an Addisin	/Change a			y Haupt I Route Numbe		T C4-		0- (-)	
th and	9	.1da L. Sh									rstown.		217		Code)	
of Health Item 27 r other tra		Method of Disposit	ion			ace of Dispo	sition (Nan	ne of	1		ate		ation - Cit		wn, State	
ant: f		4 Donation 5		amovai irom Stat		t Have					/2006					
Department of Health a Important: if Item 27 is any injury or other tra		Signature of Funera Signature of Funera L. Part 1. Enter the di shock, or heart fai	M Su	m_		1	601 P	enns	y1van	ia A	t Haven ve., Ha	gers				42
ate has been signed by the attending physician and sage 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner	res	juentially list condition, leading to immed se. Enter Underlyin ise (Disease or injur initiated events ulting in death) Last	ons, fiate g y	Due to (or a	s a consequ	,										
ed by the attending phy detached for use as th Physician/Medi	IF F	EMALE: . Was decedent pre in the past 12 mon 1 Yes 2 No 9 Unknown	ths?	3c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	death 3[Ectopic pro Other (sp	egnancy ecify)				23	3d. Date o Month		•	Year
be d	raii	II. Other significan	t conditions con	tributing to death	but not resu	ilting in the u	nderlying c	ause give	in in Part I.		23e. Did to	_			e cause of dably 4 □l	
cate has been si page 2 should l	-						·				24a. Was a autop:	sy med?	prio dea	r to con th?	sy findings	available ause of
	25.	Was case referred t	o medical						26 Place	of Death	1 ☐ Yes `	2 No	1 🗆	Yes	2 No	
S & O		examiner? 1 Tes 2 No	Н	ospital: 1 🗌 Inpa	tient 2 🗆 £	ER/Outpatier	it 3 DO	A Othe	-	rsing Horr			☐Other (Specify)	
th. : After th funeral		Manner of Death 1 Natural 5 2 □ Accident	Pending investigation	28a. Date of In (Month, D	jury Jay Year)	28b. Time o Injury	M 2	8c. Injury Work	at ? ′es 2 □ i	1	8d. Describe h	ow injury	occurred			
within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral Medical Certification: 7			Could not be determined	28e. Place of I building,	njury - At hos atc. (Specify	me, farm, str	eet, factory	, office		2	8f. Location (S City or Tow		Number	or Rural	Route Num	ber,
within 24 hours To the Funerel completely filled Medical C		Certifier 15 (Check only 2 one)	Certifying Phys Medicar Examin	ician: To the bes er: On the basis and manner:	or examinat	wledge, deati ion and/or in	occurred vestigation,	at the tim in my op	e, date and inion, deal	d place, a th occurre	and due to the o	ause(s) a late and p	ind manne place, and	er as sta I due to	ated. the cause(s	·)
o the nospitel of Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune Medical Certification	29b	. Signature and title	of certifier	2065	b.	1./	.	. License	_	18			signed (A			
0	30.	Name and address	of person who co.	mpleted cause of	death (Item	23a) (Type,	Print)	y o	5	00	ZJ c	200	1 70	HK	tell	M
State	31.	Date filed (Month, D	J. J.L.	A 32. Regis	10/7 strar's Signat	11	110 1	780	1/6-	XL	11/1/03	/	F	24/	FLA	シリ
State Registrar		NOV 1	6 2006	A STATE OF THE STA	J. J. January	1034									•	

		1	For State Registrar			tate of	Maryla	nd / Dep <i>Ce</i>	artmen rtificat			and M		Reg. No.	Z [] [] [5	364	05
	Physicia		1. Decedent's Nan	ne (First, Middle	e, Last) Delb	ort	S	haffer					2. Date of De Month 7, 2		y Ye	өг	3. Time of E	
	/Medic Examin		William 4a. Fecility Name	(If not institution				nanci			Location o		101 ., _	4c.	County of D			
		Æ	Cumber 5. Social Security		rsing			s. last birthday		berla 1 Year	and If Under:	24 Hrs.	8. Date of Bir		legany		ace (State or	Enreign
	Funeral Director		214-07-6	5083	X	2□F	92	Yrs.	Months	Days	Hours	Min.	Oct 22	", 1911 191	14	WV	try)	- Groigin
	/land ow	-	Usual Residence 10a. State	of Decedent 10b. County			10c. C	City, Town or L								1	0d. Inside City	
	e Man	ctor	MD	Alleg	gany			Cumb	perlan								1 XYes	2 🗌 No
	with the	Funeral Director	10e. Street and N		traat				10f. Zip		1502			10g. Cit	izen of Wha USA		try?	
	death	nera	11. Marital Status	Jillac Ol	12.	Was Deced	dent Ever in	U.S. 13.	Was Dece				ecity Yes or No Rican, etc.)	0-	14. Race - A			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, I'm Medicial Evant for must be notified at once.	by Fu	_	rried 2 Mars	ried	1 ☐ Yes Wes, Give Year or Da	2 No		1 ☐ Yes		Specify:	, , , , , , ,			Specify: W			
2-00	72 hou natura	ted		15. Deceden	nt's Education	on	.os. WW	16a. Dece	edent's Usua	al Occupa	ation	t of work	ina	16b. K	ind of Busin			
121	within 7	Completed	Elementary/Sec	condary (0-12)	<u> </u>	College (1-	4or 5+)	Spinne	DO NOT u	se retired)		9	Text	tile			
d 2	e filed Il Hygie other vant, Il	Be Co	17. Father's Name	12 (First, Middle,	Last)			Бринк	JI				(First, Middle	, Maiden	Sumame)	cc		
Maryland 21215-0036	should be nd Mental marked c	ToE		Shaffer				401 14 7		(7)			artha (M					
Mar	nd 2 sh aith and 27 is rr r traum		19a. Informant's I		ship (<i>Type</i> ,	wif	e	19b. Maii	Potor	nac (Street	t or Hura	Route Numb Cuml	berla	nd	tθ, Zip	1D 215	02
ore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Di	sposition 2 Cremation	3 □Rem	oval from S	****	. Place of Disp cemetery, cre	matory or o	other plac			Date		ocation - City			40
Baltimore,	it. Pag rtment rtant: I njury o			5 Other (S	Specify)		Ro	ocky Gap			1		11/8/2006		ntstone	9	1\	/ID
Ba	permit. Departr Importa any inja		21. Signatus of	holas) 4.	Sca	100	li	108	arpelli 8 Vira	Funer inia Av	ral Ho renue	me, P.A. ; Cumbe	rland,	MD 21	502		
	ă			an failure. List	r complicati t only one o	ions that ca	en line.	\sim	nter the mod	de of dyin	g, such as	cardiac (or respiratory a	arrest,			Approximate Interval Betw Onset and D	eath
	Physician /Medical		Immediate Cause disease or condit resulting in death	ion	a	Due to (s		equence of):	ta	114	0-e					l		now
	Examiner		Sequentially list of	conditions	b	`!	Den	reach	م		-					- (INKno	own
/	ted nslt	Examiner	Sequentially list of any, leading to cause. Enter Unc Cause (Disease of the cause o	or injury	₹	Due-te (d	or as a cons	equence of):	C	102(1	11au		dise	12.e		1	11/Cm	un
o,	an and rial-tra	Exar	that initiated ever resulting in death		c	Due to (d		equence of):									, , (,	
8760,	death certificate be executed e attending physician and of for use as the burial-transit	edicai			d		_			<u> </u>						-		
Box 6	death certifica attending ph d for use as th	n/Me	IF FEMALE: 23b. Was decede	ent pregnant	23c.		come of preg		□Ectopic p	roonanov	,				23d. Date of	f delive		
	the atte	Physician/M	in the past 1 1 ☐ Yes 2 9 ☐ Unknow	2 □ No			ant at time o		Other (s						Month .		Day Y	ear
P.0	that the de	by Phy	Part II. Other sign		ions contrib	outing to de	ath but not r	resulting in the	underlying o	cause giv	en in Part I		23e. Did	tobacco	use contribu	te to th	ne cause of de	eath?
ords	law requires t as been signe 2 should be												10	Yes 2	□ No 3[] Prob	ably 4 U	nknown
Vital Records,	Ф — Ф	Completed											24a. Was	DSV	prio	r ta co	psy findings a mpletion of ca	vailable luse of
tal	ian: The l rtificate ha	a	25. Was case ref	erred to medica	al						26. Place	e of Deat	1 ☐ Yes	ormed? 2 No	1 🗆	Yes	2 No	
of Vi	Physician: this certific ral director,	To B		No	Hos	1 🗀 1r	•	□ ER/Outpatie	_		er: 4 Nı		me 5 Res	idence		Specif	v)	
		tion:	27. Manner of De Natural 2 Accident	5 Pendi		28a. Date o (Montl	of Injury h, Day Year)	28b. Time Injury	of M	28c. Injur Wor 1 □	yat k? Yes 2 □	No	28d. Describe	how inju	ry occurred		,	
Division	l or Attending after death. Diractor: After Lin by the fune	Certification:	3 Suicide	6 Could	not be	28e. Płace buildir	of Injury - Al	t home, farm, s ecify)	treet, factor	y, office			28f. Location City or To			or Rura	I Route Numb	per,
۵	spital or Al ours after o naral Dirac filled in by		29a. Certifier	1 Cartifyi	ing Physici	an: To the	hest of my k	knowledge, dea	ath occurred	at the tir	ne date ar	nd place	and due to the	a cause(s	and manne	er as s	tated.	
	To the Hospital within 24 hours a To the Funaral I completely filled	edical	(Check only one)				sis of exam	ination and/or i										
	To the comp	Σ	29b. Signature a	nd title of certific	Neu-	ed	₹.				e number	100		29d. Da	te signed (A	Nonth,	Day, Year)	
	H		30. Name and ad	dress of person	9			tem 23a) (Type				7 18		4,	1/		48	
	1		31. Date in a M	1.				625		Aven	ue Cı	umbe	erland N	ИD 2	1502			
Ī	Sta Regist			OV 15		32. R	egistrar's Sig	gnature	made s									

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer **Physician** 9:45 29 Lynn Keller TIMMONS Sr. October 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) **Funeral** 1X M 2□F Yrs Director 44 5 1962 <u> 215-80-9420</u> Sept. Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 E. Antietam Street 21740 Funeral <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married □Yes 2NNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: þ Specify: 3 ☐ Widowed 4 🌠 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within. Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "reny injury or other treumatic event, Ital Mad once. Elementary/Secondary (0-12) College (1-4or 5+) 10 Fork Lift Operator Block Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ္က Leroy Timmons Catherine Banzhoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Timmons - Son 105 E. Antietam St. Apt. 5, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 10/30/06 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Minnich Funeral Home E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complication's that coused the death. Do not enter mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Ventricular Fhrallotin /Medical Due to (or as a consequence of): **Examiner** achy (ardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as our injury) Due to (or as a consequence of): Examiner The law requires that the death certificate be executed CUIC MYUCardia end that initiated events resulting in death) Last Due to (or as a consequence of): the ettending physicien e hed for use es the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical 98 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnam 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contrib its to the cause of death? ð ani DI Seone 1 Yes 2 o 3 Probably 4 Unknown Completed 121 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? ebed this certificete 1 Yes 2 (LNo or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death Check only one 70 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Ulastient 2 ER/Outpatient 3 DOA 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter deat To the Funeral Director: 6 Could not be 3 Suicide in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 12 Certifying Physician- To the bast of my knowledge. death oncurred at the time, date and place, and due to the cauca(c) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number June @ Deceta Octuber 1006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 257 AnTIFI au ϵ . 6H.0 Daniels Do Hances (is Hosessom 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 31 2006 Registra

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Andrew Latelle Thompson 2006 7, 3:10 A^M November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year tf Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Y October 3, Birthplace (State or Foreign Country) Sex 1 XM 2 ☐ F **Funeral** Months 95 Yrs Director 219-16-2303 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits ir then "naturel", or items 23a or 28a-f ehov the Medical Examiner must be notified at Director 1 ☐ Yes 2XXNo St. Mary's Maryland Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24957 Briscoe Thompson Road 20636 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) permit. Pages 1 and 2 should be filled v Department of Health and Mental Hygie. Importent: If item 27 is marked other tt eny injury or other traumatic event, the once. Agriculture Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daisy Catherine Jones Briscoe Phillip Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 36, Hollywood, Maryland 20636 Edna D. Thompson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hollywood Church of the 20a. Method of Disposition Date 20c. Location - City or Town, Slate 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State November 10. 4 ☐ Donation 5 ☐ Other (Specify) Hollywood, Maryland 2006 Nazarene 21. Signature of Funeral Service Licensee Mattingley-Gardiner Funeral Home, P.A. Truchael Kevan P.O. Box 270, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Cardiopulmonary Failure /Medical Due to (or as a consequence of): Examiner Arrythymia Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last unknown Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use es the burial-transit ASCVD unknown attending physician and Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Lymphoma 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2XXNo 1 Tes funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 🛱 ER/Outpatient 3□ DOA SIL 27. Manner of Death 28a. Date of Injury (Month, Day Year) After 1 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide within 24 hours a To the Funerel L To the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDRA MIN FOL 31. Date filed (Month, Day, Year) State NOV 0 9 2006 Registrar

			For State Registrar	ate of Maryland / I	Depa <i>Cer</i>	irtment of He <i>tificate of L</i>	ealth and I Death		iene 006	36408
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat		3. Time of Death
	Physicia /Medic		ROBERT WITTIG THOMA	AS				Novembe:	Day Ye	M
	Examin		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	Location of Deatl		4c. County of D	
			RAVENWOOD LUTHERAN V	/ILLAGE		HAGERST			WASHING	TON
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		217-10-7852	87	Yrs.			March 1	, 1919 N	Maryland
	and w	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or Lo	cation				10d. Inside City Limits
	Mary f sho	ō	Maryland Hashinatan							1 ☐ Yes 2 🔯 No
	the 28a	Director	Maryland Washington 10e. Street and Number		age	rstown 10f, Zip Code		10	Og. Citizen of What	Country?
	3e or		9723 Sharpsburg Pike			2174	0		USA	•
	death	Funerai	11. Marital Status 12. V	as Decedent Ever in U.S.	13. \	Vas Decedent of His	panic Origin? (S	pecify Yes or No-	14. Race - A	merican Indian,
21215-0036	within 72 hours after death with the Maryland iene. r then "neturel", or Items 23e or 28e-f show the Medical Evandrat must be notified at	þ	1 Never Married 2 Married 1	med Forces? □ Yes 2X No Yes, Give ear or Dates:	i	Yes, specify Cuban	Specify:	o Rican, etc.)	Specify:	/hite, etc. White
20	72 ho	Completed	15. Decedent's Education (Specify only highest grade con	1 16a	. Deced	ent's Usual Occupation	tion	tina	16b. Kind of Busine	ss/Industry
21	within ene.	nple.		ollege (1-4or 5+)	life. L	O NOT use retired)	aning most of wor	Kiilg		
	e filed within Il Hygiene. other then vent, the Me	S	11	0	Lat	ne Operat			Truck Mi	g.
nd	Q 22 D .	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, A		
<u>≯</u>	should be ind Mental I marked o	2	Griffith Thomas					ella Nine		
Maryland	2 sh and Is m		19a. Informant's Name/Relationship (Type, F			g Address (Street ar				
	ss 1 and 2 should of Health and Mer item 27 Is marke other treumatic		Marguerite J. Thomas 20a. Method of Disposition			Sharpsbu	rg Pike,		own Md.	
Ö	t of the state of		1 X Burial 2 ☐ Cremation 3 ☐ Remov	val from State cemete	ry, cren	natory or other place			oc. Location - City	or rown, state
Baltimore,	rtmer rtent njury		* 4 □ Donation 5 □ Other (Specify)	Cedar :		Mem. Par				n, Maryland
Ba	permit. Pages. Department of It Importent: If ite any injury or of once.		21. Signature of Funeral Service Licensee			Name and Address				
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death. Do	not ente	er the mode of dying	, such as cardiad	or respiratory arre	st,	Approximate Interval Between
	Physician	0 1	Immediate Cause (Final disease or condition	Sepris						Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence	of):					
8	Examiner		Sequentially list conditions, b.		nec	t inpe	chiq			3-4-63
	sit ad	iner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a consequence						
	ficate be executed physician and s the burial-transit	Examin	that initiated events c	Due to (or as a consequence		Litting				79
68760,	be e) ician buria									
387	icate phys s the	edicai	d							
Box	death certi e attending d for use a	Physician/Me	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal death □ Pregnant at time of death □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
P.0	that the		Part II. Other significant conditions contribu	ting to death but not resulting i	n the ur	derlying cause giver	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds	es ig	ed by	Antino scholie	Cardio Vaca	M	Dine	~	1 □ Ye	s 2□No 3□	Probably 4 Hunknown
Vital Records,	The taw ate has b page 2 s	Completed						24a. Was ar autopsy perform 1 Yes 2	prior death	
ïta	Physicien: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)	
of V	hysic his ce	2	1 Yes 2 No	al: 1 ☐ Inpatient 2 ☐ ER/O	tpatien		4 Lanuising n	ome 5 🗆 Reside	nce 6 Other (S	pecify)
	ling After fune	ertification;	27. Manner of Death 1		Time of njury	28c. Injury Work? M 1 □ Y	at ? es 2 □ No	28d. Describe hor	w injury occurred	
Division		ertific	3 Suicide 6 Could not be determined 28	e. Place of Injury - At home, fa building, etc. (Specify)	ırm, stre	eet, factory, office		28f. Location (Str City or Town,	eet and Number or State)	Rural Route Number,
	To the Hospitel or within 24 hours after to the Funerel Director completely filled in	dical C	(Check only 2 Madical Examiner: (n: To the best of my knowledge On the basis of examination ar and manner stated.	e, death	occurred at the time estigation, in my opi	a, date and place nion, death occu	, and due to the ca rred at the time, da	use(s) and manner te and place, and c	as stated. fue to the cause(s)
i.	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	2		29c. License			d. Date signed (Mo	
•		1							vav 2.	-00 E
00	N-3		30. Name and address of person who comple			Print)	HA 650	25 7047	v mo	21740
	11 0			T						
	Sta	to l	31. Date filed (Month, Day, Year)	32. Registrar's Signature						

		1- State of Maryland / Department of Certificate of		Mental Hy	2000	36409
		1. Decedent's Name (First, Middle, Last)	- Dealli	2. Date of De	Reg. No.	3. Time of Death
Physicia		Raymond Sholes Taylor		Month	28 06	5:000 M
/Medica			or Location of Death	1	4c. County of Death	
		Civista Medical Center Lat	lata		Charle	25
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1f Under 1 Yea Months Day 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 19.		8. Date of Bi (Month, Date of Bi		nplace (State or Foreign untry) /land
ъ		Usual Residence of Decedent			., 1321 1141)	
anylar 🛇	ž	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2X No
The second	ect	Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code			10g. Citizen of What Cou	
	ă	4615 Leonardtown Road	20601		USA	nitry:
Z Can and a second	Funeral Director		of Hispanic Origin? (S)	pecify Yes or No		
2 % %	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 N		o nican, etc.)		heic. Nhite
15-00: 72 hours "neturel;		3 ☐Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occ	nunation		16b. Kind of Business/li	
\ 	piet	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	ne during most of work ired)	king	Too. Kind of Businessyll	ludstry
d 2121 dilad within Hygiana. the than "	Completed	12 Owner/Op	perator		Electri	c Company
A TIPE	Be	17. Father's Name (First, Middle, Last)			e, Maiden Sumame)	
Tyla nould a Man marks	ို	Charles Jenifer Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streen)		Klein	City of Town Chair 7	in Code)
Ma Ma Md 2 si Md 2 si Md 2 si Md 2 si Md 2 si	1	Michael R. Taylor - Son 19660 Tower F				
S. 1 ar it Head it head other		20a. Method of Disposition 20b. Place of Disposition (Name of		Date	20c. Location - City or T	
Page nent of nry or		1 A Burial 2 Cremation 3 Removal from State United State Prinity Memorial		-2006	Waldorf, MD)
Baltimore, Marylar parmit. Pages 1 and 2 should be Dapartment of Health and Manta Important: If Item 27 is marked eny injury or other treumatic apre.		21. Signature of Funeral Service Lincensee M01246 22. Name and Add	•		01d Washingt	
m gorea					6, Waldorf,	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dishook, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	TIVE LU	NG DI	JENE	
Examiner		Due to (or as a consequence of):				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
acuted	Examiner	Cause (Disease or injury that initiated events c.				
		Due to (or as a consequence of):				
	edicai	d				
Box 6 leath certifi	Ž	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnan			23d. Date of delic	very
S, P.O. Box (es that the daath certification by the attending ba datached for use a	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)			Month	Day Year
P.C nat the d by ti	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	aura in Dani I	220 Did	tobacco use contribute to	the seven of death?
Division of Vital Records, P.O. Box 6 or of the office of the death certificate death. Director: Affar this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	2	LUNG MASS	given in Part I.		Yes 2 □ No 3 □ Pro	- /
w raqu been	ete			24a. Was	an 24b. Were aut	ropsy findings available
Re fha ta ta has aga 2	Completed			auto perf	ormed? death?	topsy findings available ompletion of cause of
ital	Be C	25. Was case referred to medical examiner?	26. Place of Dea	1 ☐ Yes		20 140
of V hyeic his ca	0	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA		ome 5 Res	idence 6 Other (Spec	ıfy)
on C ling P I. Aftar t Junara	ion:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural investigation 1 Natural investigation 1 Natural investigation 1 Natural investigation		28d. Describe	how injury occurred	
isic Mtend daath ctor: y tha	licat	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	☐ Yes 2 ☐ No	28f. Location	(Street and Number or Rui	ral Route Number
Div	Certification:	4 Homicide determined building, etc. (Specify)			wn, State)	
ospit hours unera		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the concerned at the	time, date and place	, and due to the	cause(s) and manner as	stated.
Division of Vital Record To the Hospital or Attending Physicien: Tha law requir within 24 hours after death. To the Funeral Director: Alfar this cartificata has been si complately filled in by tha funaral director, paga 2 should	Medical	and manner stated.	y opinion, death occu			``
or To Coo				64-	29d. Date signed (Month)	
,		20 None and address of severe who completed severe of death (Item 22e) (Time Brief)	583 -	U I	OE 1055	V Phod
DB 30		VEDYASAGAR ANMANGANDLA W	HITE &	LAIN	RE GREEN S, MD- 2	0.695
Stat Registra		VEDYASAGAR ANMANGANDLA 31. Date filed (Month, Day, Year) OCT 3 0 2006 OCT 3 0 2006				
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			For State Registrar	State of M	•	partment of lertificate of			iene 19. No. 0 0 6	36410
			Decedent's Name (First, Midd	fle, Last)		-		2. Date of Deat	n	3. Time of Death
	Physici /Medic		Richard	Lee	Thor	npson		October	28,2006	
7	Examin		4a. Facility Name (If not institution	on, give street and number)	•		or Location of Dea	th	4c. County of De	
			Southern Mar			Clin			Prince	Georges
	Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. last birtho 51 Yrs	Months Days	If Under 24 Hrs Hours Min	8. Date of Birth (Month, Day, March I	Year) 9. B	irthplace (State or Foreign Country)
	Director		218-64-5561 Usual Residence of Decedent					March 1	9,1900	Maryland
	nyland how		10a. State 10b. Count	·	10c. City, Town o	Location				10d. Inside City Limits
	e Ma	cto	MD	Charles	Wa	ldorf				1 □ Yes 2X No
	ith th	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What	Country?
	e 23a	rai	25 Blackpo	12. Was Decedent	Ever in 11 C		20602	Consider Van as No	USA	nencan Indian,
	ter de ritem	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Ma	Armed Forces?	No	Was Decedent of If Yes, specify Cut	oan, Mexican, Pue	rto Rican, etc.)	Black, Wh	
99	al', or	ρ	3 Widowed 4 Divorce	If Yes, Give 43		1 ☐ Yes 2 🔂 No	Specify:		Specify:	White
215-003	within 72 hours after death with the Maryland ane. then 'natural', or iteme 23a or 28a-f ehow ite Madieal Exemiter mast be notified at	Completed		nt's Education est grade completed)		ecedent's Usual Occu		orkina	16b. Kind of Busines	s/Industry
	Althin Nen	np l	Elementary/Secondary (0-12)	College (1-4or	5±)	e. DO NOT use retire Ainter	9d)	9	D = ! !	
2	filed w Hygie other ti		17. Father's Name (First, Middle	l (ast)		4 T I I C C I	18 Mother's Na	ıme (First, Middle, M	Painti	ng
au	d al	9 Be	Francis E. M				Helen			
Maryland 21	s 1 and 2 should f Health and Men item 27 ie marke other traumatic	ဥ	19a. Informant's Name/Relation		19b. M	ailing Address (Stree	t and Number or R			Zip Code)
	and 2 salth ar n 27 le		Sandra Thomp	son/Wife	25	Blackpoo	ol Circ	le.Waldo	rf.MD 2	0602
e,	ges 1 a t of Hea if Item or othe	1.5	20a. Method of Disposition	2 🗆 🖰 🖰	20b. Place of D	sposition (Name of	eco)	Date 2	20c. Location - City of	or Town, State
Ĕ	Pages ment of ant: If it ury or o	١,	1 Burial 2 □ Cremation Donation 5 □ Other (Trini	y Memor:	ial 11/	2/06 W	/aldorf,	Maryland
Baltimore,	permit. Pag Deportment Important: I any njury o		21. Signature of Funeral Service	e Licensee M00	945	22 AREHAR	r-echol:	S FUNERA	L HOME,	P.A.
		9	23a. Part1. Enter the disease, of	or complications that cause	d the death. Do not	enter the mode of dv	 Mary : ing. such as cardia 	S AVE. I	a Plata	MD 20646
	Dhysisian		shock, or heart failure. Lis Immediate Cause (Final	st only one cause on each li	ne.	2 1	' 1			Interval Between Onset and Death
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	Examiner		Sequentially list conditions	HU	naw I	mune	Olefic	chief 5	yorkho.	funtion
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	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of):					-
8760,	The law requires that the death certificate be executed sie hes been signed by the attending physician and bage 2 should be datached for use as the burial-transit		,	Due 10 (01 as	a consequence on.					
687	ficate physics the l	edicai		d.						
ŏ	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		205			23d. Date of d	elivery
m	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a	2 □ Fetal death t time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	;у 		Month	Day Year
o.	at the	hys	9 🗆 Unknown							
	res that the de signed by the a be datached f	ρ	Part II. Other significant condit	ions contributing to death b	out not resulting in th	e underlying cause gr	iven in Part I.			to the cause of death?
ord	w require been si should b	eted	and 1	100	corosi	2 4 1h	1	7		Probably 4 Minknown
Division of Vital Records,	hes b	Completed	Chrome O.	85/ Mul	re Dul	may 1	roland	24a. Was ar autops perform	24b. Were prior to death?	autopsy findings available completion of cause of
a								1 ☐ Yes 2	1 □ Ye	es 2 No
Ĭ	Attending Physician: ir death. ector: After this certificaby the funeral director.	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Outpa	1004 Ot	hac	eath (Check only one		
ō	g Phy er this eral d	5	27. Manner of Death	28a. Date of Inju		e of 28c. Inju		Home 5 Reside		н о спу)
<u></u>	ttending death. ctor: Afte y the fun	atio	1 Natural 5 ☐ Pend 2 ☐ Accident invest	ing (Month, Da tigation	i <i>y Year)</i> Inju		ork?]Yes 2 □ No			
<u>S</u>	i or Attending after death. Director: After in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 286. Place of In	jury - At home, farm	street, factory, office		28f. Location (Str City or Town		Rural Route Number,
⊡	ospital or A hours aftar uneral Dire									
	To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To the best d Exeminer: On the basis of and manner st	of examination and/o	eath occurred at the t r investigation, in my	ime, date and place opinion, death occ	e, and due to the ca curred at the time, da	use(s) and manner ite and place, and di	as stated. ue to the cause(s)
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of cepti	Br)	-	29c. Licen	se number	29	d. Date signed (Mo.	nth, Day, Year)
)	> F 0		> HAR	1/2/		50	454	0	corses	29,06
1			30. Name and address of period	n who completed cause of o	death (Item 23a) (Ty	pe, Print) A	rastoo	Yazdani		
	365		9801 Creffy	The Sue Si	-l 3-4	1 87 600	spen	2 orb s	20 40	
	Sta Registr		31. Date filed (Month Day, Year)	3 1 2006 32. Redistr	rar's Signature	Speak				
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			State 1	te of Maryland				-	iene	
			For State	le of Maryland	•	rtificate of i			eg. No2 11 11 5	361.11
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dear	th	3. Time of Death
	Physicia		Kenneth Frederi	ck Thom	pson			Month Octobei	Day Yeer 27,2006	10:03A ^M
	/Medic Examin		4a. Fecility Name (If not institution, give street a			4b. City, Town, or	Location of Death		4c. County of Deat	
			Civista Medical C				Plata		Cha	rles
	Funeral		5. Social Security Number 6. Sex 1. M 2.	7. Age (In yrs. Ia	is <i>t birthd</i> ay) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	9. Birt (Year) Co	hplace (State or Foreign untry)
	Director		215-48-2073 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	86			reb	ruary	27,1920	Maryland
	yland		10a. State 10b. County		Town or Lo					10d. Inside City Limits
	8a-f s	cto	MD Charles		Bel E	lton				1 ☐ Yes 2 ☐ No
	deeth with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number			10f. Zip Code	00611	1	log. Citizen of What Co	untry?
	s 23	Funeral	9285 Fifth Stree	s Decedent Ever in U.S	3. 13.	Was Decedent of H	20611	ecify Yes or No-	USA 14. Race - Ame	nican Indian,
_	r Item	Fun	1 Never Married 2 Married 1 □	ed Forces? Yes 2 X No	- 1	Was Decedent of H		Rican, etc.)		
000	ours a	þ	3 ☐ Widowed 4 MDivorced Yes	es, Give That or Dates:		1 □ Yes 2√√2 No	Specify:		Specify: W	hite
ე ი	o 72 hours after deeth with the Marylan "natural", or Items 23a or 28a-1 show salcal Exandrer must be motilled at	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	king	16b. Kind of Business/	Industry
7	within ane. than	mp	Elementary/Secondary (0-12) Col	lege (1-4or 5+)		ırmer	1)		Farm	ina
א מ	filed Hygid Sther ent, I	C	17. Father's Name (First, Middle, Last)			LIMEL	18. Mother's Nam	e (First, Middle,	Maiden Sumame)	Ing
a	Hental Red of tic ev	To Be	Peter Noble Thomp	son			Doroth	у Кеу (Compton	,
ar	and A		19a. Informant's Name/Relationship (Type, Prin	nt)					r, City or Town, State,	Zip Code)
Σ,	s 1 and 2 f Health item 27 other tre		Susan Thompson/Da	ughter	1	Box 93		Date Date	20611	Town State
<u>o</u>	iges 1 it of H if ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remova			osition (Name of matory or other place			20c. Location - City or	
Baitimor	tant tant		4 □Donation 5 □ Other (Specify) 21. Signatthe of Funeral Service Licensee	M0/094					6 Port To	
a B	Depermit Depermit Impor eny ir		19 // /			AREHART	-ECHOLS	FUNERA	AL HOME, P	.A.
		_	23a. Part1. Enter the disease, or complications	that caused the death.	. Do not en	ter the mode of dyir	Mary S ng, such as cardiac	or respiratory arr	a Plata,	Approximate Interval Between
	Physician		shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	lentres	ulan	· Film	llate	~		Onset and Death
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	Examiner		Sequentially list conditions, b	Delale	NE	ards	myon	othe		
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9	0 0	cal	d2	athero	-2-	lenon				
9	The law requires that the death certificate site has been signed by the attending phy. page 2 should be detached for use as the	Med	IF FEMALE:							
Rox	ath ce ttendi or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	es, outcome of pregnar Live birth 2 Fetal	death 3	Ectopic pregnanc	y		23d. Date of de Month	livery Day Year
	the a	ysic	1 Vac 2 No	Pregnant at time of de Unknown	eath 51	Other (specify)				
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Vital Records,	quires n sign Jld be	Completed by	COPD, Mitral 1	valve pr	lays	se , mil	tral_	1 🗆 Y	es 2 No 3 □ P	robably 4 Unknown
ပ္ပ	aw requires is been si 2 should t	plet	valve regurgitate	in Left	atris	I enta	rgement	24a. Was a	an 24b. Were a	utopsy findings available completion of cause of
ž	The law ete has page 2 s	Com	Old Cerebraneau	las infar	etro	n_i	0	perfor	med? death?	2 □ No
/ita	clan: ertific ector,	Be	25. Was case referred to medical examiner? Hospita	<i>l</i> ·		. 0#	000	th (Check only o		
	Physi this o	- T	1 Tes 28 No	. Date of Injury	ER/Outpatie	nt 3L DOA	4 🗀 Nursing n		ence 6 Other (Spe	ocify)
o	ding th: After fune	tlon	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	Wo	rk? Yes 2 □ No			
Division of	Atten r deal ector by the	Ifica	2 Could not be	. Place of Injury - At ho building, etc. (Specify		reet, factory, office		28f. Location (S City or Tow	Street and Number or R	ural Route Number,
ā	tal or A	Certification:	4 Notified	building, etc. (Specify	·/			ony or row	, 0.2.0,	
	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funaral Director: After this certificete his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: (Check only 2 Medical Examiner: On	n the basis of examinat						
	the b	Medical	one) and title of certifier	nd manner stated.		29c. Licens	se number		29d. Date signed (Mon.	th, Day, Year)
)	Z × Z 8		During	Act 1	Luco	NA				
Į.			30. Name and address of person who complete	ed cause of death (Item	23a) (Type	. Print)	,1			27, 2006
ل	13		Dr. Haul E Pritche	HSR. 11	860	egrang	e Ave.	Lapla	eta, Md	20646
137		ate	31. Date filed (Month, Day, Year) 0CT 3 1 200	32. Registrar's Signal	ture	Spark		'	-	
	Regist	di		1	_					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artment o			-	giene	06	36412
	Physic	ian	1. Decedent's Name (First, Middle, Last	rta Tollenge					2. Date of Dea		Year,	3. Time of Death
	/Medi Exami Funeral Director		4a. Escility Name (If not institution, give	street and number)	Me s. last birthday)	HaV If Under 1 Y	ear If Und	ler 24 Hrs. s Min.	B. Date of Birt (Month, Day Nov. 16	4c. County HOV Year) 5,1920	9. Birthp Cour	lace (State or Foreign haryland
	iand ow		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation				,		0d. Inside City Limits
	he Mary 28a-f sh culling	ector	Maryland Harfo	ord			e de Gi	race				1⊠Yes 2□No
	th with	al Dir	10e. Street and Number 973 Chesapeake Dr	ive		10f. Zip Cod	de 210	78		10g. Citizen of 1	What Cour U.S	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic syent, the Medical Evantree must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 內 No If Yes, Give Year or Dates:		Was Decedent If Yes, specify (1 ☐ Yes 2 ☑			cify Yes or No- lican, etc.)	14. Rac Blac Specify	e - Americ ck, White,	
Maryland 21215-0036	within 72 ho ene. than "nsturi to Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) Twelve Years	cation e completed) College (1-4or 5+)	(Give	dent's Usual Ookind of work do	one during m stired)			16b. Kind of Bo C & P To Havre do	eleph	dustry one ce,Marylan
nd 2	e filed within al Hygiene. I other than " vent, the Me	Be Co	17. Father's Name (First, Middle, Last)		1	= Epitori				Maiden Suman		
ryla	2 should be fi and Mental H Is marked of raumatic avair	10	Hobart Wa							Philli	-	
	alth an 27 is r		19a. tnformant's Name/Relationship <i>(Ty</i> Phyllis Simmons	(sister)		ng Address <i>(Str</i> P ini on]				r, City or Town, are 1	<i>State, Zip</i> 9701	Code)
Jore	00		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	lemoval from State	Place of Dispo	natory`or other	place)	Da		20c. Location -		
Baltimore,	permit. Pag Department Important: I sny injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		Le	Name and Ac	dress of Fac	on & S	on Fune	eral Hor	<u> </u>	Pennsylvania .A.
8760,	Physician and physician and physician and physician and physician and strength and physician and phy	dical Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	ath. Do not enter yellow equence of): (www.	er the mode of	dying, such a	s cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death C CL Cuy
P.O. Box 68	it the death certif by the attending tached for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregna				23d. Date Mor	e of delive	ry Day Year
	sign d be	þ	Part II. Other significant conditions cor	tributing to death but not re	sulting in the un	derlying cause	given in Part	t I.	23e. Did tot			e cause of death?
Division of Vital Records,	The law ete has b page 2 s	e Completed	25. Was case referred to medical						100	ned? 2 → No 1	rior to con eath?	sy findings available apletion of cause of
Ž	S	To B	examiner?	ospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient	3□ DOA		ursing Home	Check only on 5 ☐ Reside	e/ ince 6 □Othe	r (Specify)
οuo	Attending Prade transport of the function of t	tlon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Vork? Yes 2	i	d. Describe ho	w injury occurre	bd	
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Aller th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre				f. Location (St. City or Town	reet and Numbe , State)	or Rural	Route Number,
	Hospital or 24 hours afte Funeral Dir etely filled in I	Medical	29a. Certifier 1 Certifying Phys (Grock only one) 2 Medical Examin	ician: To the best of my kn ler. On the basis of examin and manner stated.	owledge, death auon and/or inv	occurred at the estigation, in m	time, date a y opinion, de	and place, and eath occurred	d due to the ca at the time, da	iuse(s) and mar ate and place, a	ner as sta nd due to	ited. the cause(s)
)	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Lice	anse number	09	25	od. Date signed	(Month, D	Day, Year)
			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, F	Print)	n 3+-	Mar	re De	Com	111	2 Ne78
M.	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	0.00000				June	1 (1)	×1618

06-08466	
William F	Thomas

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene William F. Indmas 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day November 7, 2006 1012 hrs Medical Examiner William Frederick Thomas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cambridge Dorchester Dorchester General Hospital 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Foreign Months Hours Director 214-10-0734 86 April 23, 1920 1 X M 2 Usual Residence of Decedent 10d, Inside City Limits 10a State 10c City, Town or Location 10b. County 28a-f show MD Dorchester 1 Yes 2 X No Cambridge notified at once, hours after death with the Maryland Director 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 100 Bayview Ave. 21613 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. must be Armed Forces? White etc. 1 Never Married 2 Married 1 X Yes 2 white If Yes, Give Year 1 Yes 2 X No specify. Specify WWII ten 27 is marked other than "natural", traumatic event, the Medical Examiner ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 Baltimore, MD 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. office manager city government 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Huffington Thomas Minnie Stack 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt: If item 27 i David Thomas son 8595 Wintergreen Place, Delmar, MD 21875 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 🔀 Burial 2 Cremation 3 Removal from State Department or Important: injury or oth Donation 5 Other Specify 11/10/06 Cambridge, MD Greenlawn Cemetery 21. Sig 🗼 re of Funeral Service License 22. Name and Address of Facility Thomas Funeral Home P.A. Ilam 700 Locust St., Cambridge, MD Approximate Interval rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** failure List only one cause on each line. Between Doset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED attending physician or use as the burial #23a,27,perME, g862, 12/01/06 TT Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ö ۵ Yes 2 No 3 Probably 4 V Unknown ۵ Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed death? certificate Yes 2 V No 25 Was case referred to medical 26 Place of Death (Check only one) the Hospital or Attending Physician: Be Other₄ Hospital: 1 🗸 Inpatient 2 ER/Outpatient 3 DDA Nursing Home 5 Residence 6 Other this 1 V Yes 2 No ٩ After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending death . To the Funeral Director: Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) O.C.M.E. November 8, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Ana Rubio MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) NOV 13

State Registrar

DHMH 17 Rev 1/2001

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2006

06-08563 John Richard Tilch

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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25d. Bale signed (Wolfith, Day, Year)		Σ	29b. Signature and title of dertifie 29c. License number 29d. Date signed (Month, Day, Year)
O.C.M.E. November 11, 2006 30 Name and address of person who completed cause of death (Item 23a)		-	
Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	_		Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State 31 Date filed (Month, Day Year) 5 2006 32. Registrar's Signature Registrar			31 Date filed (Month, Day Year) 5 2006 32. Registrar's Signature

		. For	State of Maryla	nd / Depa	artment of H	lealth and	Mental Hy	giene 200	00115
		1 - State Registrar		Cei	rtificate of	Death		Reg. No. 200	
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s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Is marked other then "naturel", or items 23s or 28s-f show other treumatic event, the Medical Extrainer must be notified at	1	Janice W. Vaughn				le Road,	Apt. 20		Spring, MD 209
of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	1	Place of Dispo cemetery, crea	osition (Name of matory or other pla	ce) Nov	Date 8,	20c. Location - City	or Town, State
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5		30. Name and address of person who S. M. Nayar, M, D				City, M	D 20722		
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Decoders Secretary Control C				For State Registrar	State of	Marylar	nd / Depa	artment of I	Health a Death	and Men		ene2 () ()6	36416
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South Section Number Color				4a. Facility Name (If not institution	n, give street and numi	ber)		4b. City, Town,	or Location o	of Death		4c. County of	Death	
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	Examin	er	4a. Facility Name (If not institution,				4b. City, Town, or		of Death			county of Dear		
54	Funeral	70 M	St. Mary's Nurs 5. Social Security Number 6		7. Age (in yrs.	last birthday)	Leonard If Under 1 Year	If Under		8. Date of Bir	th	9. Birl	thplace (State	or Foreign
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<u> a</u>	ould b Menta arked	To	Robert Theodo	ce Herber	t					y Roze				
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DIVISION	il or Attandi after death. I Director: A d in by the fu	ficat	3 ☐ Suicide 6 ☐ Could no	t be 300 Place	of Injury - At ho	ome, farm, sti	eet, factory, office	103 2		8f. Location (Street and	Number or Ri	urai Route Nun	nber,
2	after Dire	Certification;	4 Homicide	buildi	ng, etc. (Specif	y) .	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or To	wn, State)			
	splite hours inerel y fille	Saic	29a. Certifier 1 Certifying (Check only 2 Medical E)	Physician: To the	best of my kno	wledge, deat	occurred at the tim	re, date an	nd place, a	nd due to the	cause(s) a	nd manner as	s stated.	
	To the Ho within 24 To the Fu completel	ledicai	one)	and man	asis of exa <i>m</i> ina ner stated.	and/or in	vestigation, in my or		ui occurre					5)
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	4-0		30. Name and address of person w	15.67	e of death (Item	23a) (Type,	1 ASSOC	181E	55,	GON	BAD	Town	V M	D
Sept.	Sta Registr		31. Date filed (Month, Day, Year)	100b Be	egistrar's Signa الكر معما	April	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 20c State of Maryland / Department of Health and Mental Hygiene Registrar WCHD/SH 11/3/06 per FH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** ROBERT WILLIAM WHITNEY November 2006 11:43 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1.□ M 2□ F Yrs. 58 ΚÝ 400-66-9459 16,1948 Director June Usual Residence of Decedent r 28a-f show notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1√E Yes 2 No Director KY Warren Bowling Green 10a. Citizen of What Country? 10e Street and Number 10f. Zip Code ö must be 687 Beech Bend Road 42101 USA e filed within 72 hours after death val Hygiene. Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or items traumatic event, the Medical Examiner mu 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 2 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Computer Data Computers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ is marked William Porter Whitney ည Jean Landers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Jean Whitney (Mother) PPO Box 444 Bowling Green, Ky 42102 20c. Location - City or Town, State Bowling Green, KY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Department of Important: If it any Injury or o 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview Cemetery 11/06/06 Boling Green, Ky 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.C.Kirby&Son Fun. Home H11101035 832 Broadway Ave.Bowling Green, Ky. 42101 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OROPHARYNY CELL LARCINOMA 2 MONTHS **Physician** SQUAMOUS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the IF FEMALE: ISe 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 2. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI November 3, 2006 D0056314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PREDERICK MD 21702 JOHNSON DRIVE 46 B THOMPS BINDU GEDRGE OTH-1 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 0 3 2006 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U U 6 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Theodore Wannebo Αм 5:50 October 27, 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1**∑**M 2□ F 79 Yrs 471-20-3689 March 26, 1927 Minnesota Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2√ No Bremerton Washington Kitsap 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 98312 U.S.A. 6111 Widgeon Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1√GXes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2CXNo Specify Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Theodore Wannebo Anetha Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1669 Chinford Trail Annapolis, Maryland 21401 Joel Wannebo/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/30/2006 Baltimore, Maryland Baltimore Crematory Trunery Service Lice 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 1064 Immediate Cause (Final disease or condition resulting in death) Due to (or as a Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 2 Fetal death 3 DEctopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown

permit. Pages 1 and 2 should be filed within 72 hours after deet Derjement of Health and Mental Hygiene. Important: If Itam 27 is marked other them? any injury or other traumer. **Physician** /Medical Examiner

Physician

Examiner

Funeral

Director

or iteme 23a or 28a-f show aniner must be notified at

Direct

Completed by Funeral

Be

2

the Maryland

/Medical

Physician/Medical þ Be Completed

29b. Signature and

Examine

Certification; To

Medical

or Attending Physician: The law requires that the death certificate be executed ettending p ed by the deteched been sig this certificete After s after death.

I Director: A in by the fu within 24 hours aft To the Funeral Di completely filled in ro the Hospital

P.O. Box 68760,

Division of Vital Records,

8+1 State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes 1 Thpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? i Ratural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print) 30. Name and address of person who complet

4 Dunknown

24b. Were autopsy findings available prior to completion of cause of death?

2

31. Date filed (Month, Day, Year)

3 0 2006



		•	For State Registrar	State of I	Maryland		artment rtificate			ınd M		jiene _{eg. No.} 2 ()	06	36420
н	Physicia	an	1. Decedent's Name (First, Middle		. O W/:1						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution		Owen Wil	t	4b. City, T	own or l	Location o	f Death		3 4c. Count	y of Death	1835 M
	Examin	er	WMHS-Brace		npus		Cui		1	ana	L	_	egar	y
	Funeral		5. Social Security Number		Age (In yrs. last		If Under 1	Year Days	If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	Coui	place (State or Foreign
	Director		214-46-3408	1 M 2□ F	59	Yrs.					November		L	Maryland
	and II		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						1	10d. Inside City Limits
	Mary Fled	ţō	Maryland	Allegany					Barto	on				1 □ Yes 2 No
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene do ther than "natural", or iteme 23s or 28s-f show event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number				10f. Zip (Code			1	l0g. Citizen of		-
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	er de	nue	11. Marital Status 1 □ Never Married 2 Marr	12. Was Decede	es?	13.	Was Decede If Yes, speci	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14. Ha	ice - Ameri ack, White,	
38	urs aft	by	3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 If Yes, Give [®] Year or Date	es:		1 ☐ Yes 2	No	Specify:			Speci	ify:	White
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2	ithin 7 ne. nen "r	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	kind of work DO NOT use		t Forer		.9		Paper	Mill
2	filed w Hygier other th	Co	17. Father's Name (First, Middle,		Į						(First, Middle,	Maiden Suma		IVIIII
and	d be f antal h ted of	o Be	Tr. Factor 3 Harris (Frist, Fristis)	Thomas Ower	n Wilt							lma Beer		
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ita Mi	ဥ	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailii	ng Address	(Street a	nd Numbe	or or Rura	l Route Numbe	r, City or Town	n, State, Zij	Code)
	and 2 eelth a m 27 is		Genevieve	Wilt - Wife					Miller		S.W., Bar			
Baltimore,	Ite.		20a. Method of Disposition 1 XBurial 2 Cremation	3 □Removal from St	l cam	etery, crei	nsition (Nam	her place		Ŋ	ate Vovember	20c. Location		
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Ba	permit. Page Department of Important: If any Injury or once.		I lam	JKuj	/		z. Namo and				Kenzie Fu			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	ised the death.	Do not ent	ter the mode				reet, Lona r respiratory arr		11.213.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	N one cause on each	1 1	dak	in's		ly	an	noma	λ	1	Onset and Death
	/Medical		resulting in death)	a	as a consequer	-			-	-1			,	
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3760,	eath certificate be executed ettending physicien end for use as the burial-transit	call		d										
89			IF FEMALE:	1										
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Fetal de	ath 3	Ectopic pre						ate of deliv Ionth	ery Day Year
<u>o</u>	the de / the e	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow	nt at time of deat m	n st	☐ Other (spe	ecily)						
۵.	The law requires that the death certifica ate hes been signed by the ettending ph page 2 should be detached for use as the	by Ph	Part II. Other significant condition	ons contributing to dea	th but not resulti	ng in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use co	ntribute to 1	he cause of death?
Vital Records,	w requires been sig should b	ed b			- · · · · · · · · · · · · · · · · · · ·						1 🗆 Y	es 2 🗆 No	3 ☐ Pro	bably 4 Unknown
eco	e law requ hes been je 2 should	Completed									24a. Was a autop	sy	prior to co	opsy findings available ompletion of cause of
<u> </u>	The cete h	Con									perfor	med? 200 No	death? 1 ☐ Yes	2□ No
Vita	Physicien: r this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:				Othe	r		(Check only of			
ō	Phys r this aral di	- To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of (Month,		3b. Time o	nt 3□ DO. of 21	Bc. Injury Work	4 🗀 140		me 5 ☐ Resid 28d. Describe h			TY)
io	Attending or death.	atio	1 ► Natural 5 □ Pendir 2 □ Accident investi		Day rear)	Injury	М		r ∕es 2□	No				
Division	I or Atte after de Directo I in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 200. Flace o	f Injury - At home g, etc. (Specify)	e, farm, st	reet, factory	, office			28f. Location (S City or Tow		ber or Rur	al Route Number,
	urs aft		Constitution of Constitution	ng Physician: To the b		dan dans		at the time	- data an	d stage	and due to the	(a) and a		
	the Hospital bin 24 hours a the Funarel I npletely filled	Medical	29a. Certifier (Check only 2 Medical one)	Examiner: On the bas and manne	is of examination	and/or in	vestigation,	in my op	pinion, dea	th occurr	ed at the time, o	date and place	, and due t	o the cause(s)
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funarel Director: Atter this certificate he completely filled in by the funeral director, page	Me	29b. Signature and title of certifie	11110	?		29c	License	number			29d. Date sign		Day, Year)
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		1-	30. Name and address of person	. 10-			Print)	nha	orla.	nd	mD	2160	2	
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 11:00AM EBA VERMEL WAINWRIGHT 25, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SALISBURY REHAB & NURSING CENTER 21804 SALISBURY, MD. WICOMICO If Under 1 Year | ff Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 4 Amounth, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2004 89 MD Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f ehow event, the Medical Examiner must be notified at 1 ☐ Yes 2 🐼 No Directo YASKIN MD WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Wainwoigh 21865 CAPITOLA BD USA "nature!', or items 23a Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) permit. Peges 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if itam 27 is marked other then 's any injury or other treumatic event, the Megang injury or other treumatic event, the Megang Elementary/Secondary (0-12) EDUCATION TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KBURY WAINWRIGHT MAUDE JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ebo 20b. Place of Disposition (Name of cametery, crematory or other place)

Date

20c. Location - City or DASHIELL MENEW 20c. Location - City or Town, State 20a. Method of Disposition 4 Donation 5 Dother (Specify)

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. TYMSKIN, MID Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician 01 gean /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed ettending physicien and I for use as the burial-trar Due to (or as a consequence of): O. Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to compfetion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 22 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 🗌 Yes 2 3-NO 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours effer death.
To the Funerel Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ANatural 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Trans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 31. Date filed (Month, Day, Year)

OCT 3 1 2006 32. Pegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 'Amend' item 1 - State Registrar #8 per FH/wichd/11-2-06/dls Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 27, 2006 Riall White III **Physician** Edward 4:42 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Center for Hospice Care Towson 8. Date of Birth8/12/24 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 971271924 Maryland 1**X** M 2 □ F 82 218-16-8065 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County ral", or Items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Timonium Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21903 USA 100 Daleview Court Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after of teath and Mental Hygiene. m 27 is marked other than "natural", or iter 1 <u>Army</u> 1 f Yes, Give Army Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: white 3altimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Electrical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Elliott Edward Riall White Jr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
100 Daleview Court, Timonium, MD 21903 19a. Informant's Name/Relationship (Type. Print) Elizabeth White/wife permit. Pages 1 and 2: Department of Health a important: If item 27 Is any injury or other trau 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/30/06 Salisbury, MD Parsons Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service-Licensee 22 Name and Address of Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final weks Physician nemorrhagic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examine: 1 ∐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Nos Pr 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident Injury

Box 68760, P.O. or Vital Records,

Division

To the Hospital or Attending Physician: within 24 hours after death.

Jo the Funeral Director: After this certifica completely filled in by the funeral director, I.

within 24 hours a

To the Funeral I

completely filled 9

State Registrar

Medical

AARON CHARNES, NO OCT 3 31. Date filed (Month)

3 0

6 ☐ Could not be determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

6601

and manner stated.

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

St Bronne N. Charles

32. Registrar's Signature

Perlie

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Physician

1 - State Registrar

William

1. Decedent's Name (First, Middle, Last)

4a. Fecility Name (If not institution, give street and number)

Allegany Cumberland Lions Center for Rehabilitation If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, May 31, Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) OH 10 M 20 F Director 296-22**-**6595 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event. The Marilical Eran, it et must be notified at MD Allegany Rawlings 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21557 USA 17904 First Street Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1. ☐Yes 2 ☐ No 1 ☐ Yes 2 No Specify: white Specify: Year or Dates: WWII þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Potomac Farms Dairy 12 laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event once. Grace Shipman Wharton William Wharton, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17904 First Street Rawlings MD 21557 Mary Wharton wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/13/2006 Flintstone Rocky Gap Veterans Cemetery MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, who k, or heart failure. List only one cause on each line. Immediate Cause (Final Advanced **Physician** 2years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of). Examine the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death al or Attending P after death. After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier wowork8hm NOV 10, 2006 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Frostburg MD Dr. Wonsock Shin 48 Tarn lerrace 31. Date filed (Month, Day, Year) 32. Signature State NOV 1 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Wharton

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene U 0 6

4b. City, Town, or Location of Death

2. Date of Death

November

3. Time of Death

2:30 PM

Year

2006

4c. County of Death

06-07955 Please Type or Print in Black Indelible Ink David Williams State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 23, 2006 David Williams Medical Examiner 1331 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Cheverly Prince George's Hospital Center Prince George's 5. Social Security Number UTIK 6. Sex If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign . Age (In yrs. last birthday **Funeral** Country 62 Months Davs Hours Min 05-21-1944 Director South, Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County X Yes 2 No 28a-f show d at once, Prince George's Temple Hills hours after death with the Maryland Director 10e. Street and Numbe 10a Citizen of What Country 3001 Branch Avenue Apt. 212 20748 23a or 28 notified U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 11. Marital Status or items Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Never Married 2 Married Yes Specify Black 1 Yes 2 X No specify: Widowed Divorced If Yes. Give Year Examiner 3 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 F nent of Health and Mental Hygiene. ant: If item 27 is marked other than "r or other traumatic event, the Medical E **3altimore, MD 21215-0036** 12 Years 17. Father's Name (First, Middle, Last 18 Mother's Name (First, Middle, Maiden Surname) David Williams Elary Hudson 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health and M Important: If item 27 is m injury or other traumatic c 123-27 Milburn Street Springfield Cardens, NY 11413 Deetra Scott/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/04/2006 Wash., D.C. Mt.OLivet Cemeter Donation 5 Other S 22 Name and Address of Facility JOHN T. RHINES FUNERAL drature of Fune 12th ST, N.E. WASH. D. C20017 3015 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physiciar** failure. List only one cause on each line Retween Onset and /Medical Death Intracerebral hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Hypertensive atherosclerotic cardiovascular disease Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical XUNPENDED physician a X AMENDED #5.16a-b, 23a-b.27.perE. g862, 12/21/06 TT Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of perform death? Yes 2 1 🗸 Yes No 26.Place of Death (Check only one the Hospital or Attending Physician: 25. Was case referred to medica Other₄ examiner? 1 / Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other this 1 V Yes 27. Manner of Death 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural Yes 2 5 Pending 24 hours after death Funeral Director: Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner as started Medical To the 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registra

DHMH 17 Rev 1/2001 OCME 2006

Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year)

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

October 24, 2006

	1	For Stete Registrar	State	of Mary		partme <i>ertifica</i>				lental Hy	giene Reg. 20.0 ()6	36425
Physicia	n	1. Decedent's Name (First, Middle Grace Markel								2. Date of De. Month Novemb	Day	Year 2004	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution,		umber)		4b. City	, Town, or	Location	of Death	IVOYCINE	-	ty of Death	
Latimic		Washington Cour	ty Hospi	tal		Hag	gerst	own			Wash	ingto	n
Funeral Director	- 1	5. Social Security Number 181–32–3257	6. Sex 1 ☐ M 2 ☐ NE	7. Age (In	yrs. last birthd 65	Months		If Under Hours	Min.	8. Date of Birt (Month, Da Dec. 26	y, Year)	Cou	place (State or Foreign ntry) sylvania
p s	-	Usual Residence of Decedent 10a. State 10b. County		100	c. City, Town o	r Location						·1	10d. Inside City Limits
Aaryla r eho	_												1 Yes 2 No
28a-	ec l	Maryland Washing 10e. Street and Number	gton	Si	mithsbu		ip Code				10g. Citizen o	f What Cou	ntry?
3a or	2	22038 Mohawk Dr				2	1783				U.S.A		
deat me 2	ner	11. Marital Status	12. Was De Armed F		in U.S.	13. Was Dec	edent of Hi	spanic Or	igin? (Spe	ecify Yes or No Rican, etc.)	14. Ra	ace - Ameri ack, White	
	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced		2 No		1 🗆 Yes		Specify:		, , , , ,	Spec		
natur	ied ed	15. Decedent (Specify only highest	s Education	()	16	ecedent's Us	rork done d	lurina mos	st of work	ina	16b. Kind of	Business/Ir	ndustry
ithin 7	Completed	Elementary/Secondary (0-12)	1	(1-4or 5+)	lit	e. DO NOT	use retired,)					
led w	3	12	actl		Da	ta En	try	19 Moth	or's Name	(First, Middle,		rance	
ire, Marylania Z.I.Z. s. 1 end 2 should be filed within Health, and Menial Hygiene. Item 27 is marked other than other traumatic event, Ir. M.	10 Be	17. Father's Name (First, Middle, L Gideon Markel	.ast/							ary Wea		1/1/0/	
Mary d 2 shou th and M 7 is mar traumal	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. M	ailing Addres	ss (Street a			Al Route Number		n, State, Zi	p Code)
re, Mary		Allen J. Yoder /	Husband		220			Dr.		hsburg			
Dallimore, permit. Peges 1 en Deperment of Heal Important: If Item 2 any Injury or other ance.		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from		Ob. Place of Di cemetery,	sposition (Na crematory or	ame of other place	9)		Date	20c. Location	n - City or T	own, State
DESILITION Permit. Peges Department of mportant: If it nny injury or o		4 □Donation 5 □ Other (Sp	ecify)		Rest Ha								Maryland
Dan permit Deper Impor any In		21. Signature of Funeral Service I	censee		_					t Haven			
4 44244	+	23a. Part1. Enter the disease, or	complications that	caused the	death Do not							Mary	1and 21742 Approximate
Pnysician		shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on	each line.	Car di	á l	n	2 2 C	fice	or respiratory at	1031,		Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to	o (or a a co	nsequence of):		1						
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and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	o (or as a co	nsequence of):						-		
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th cert lendin	an/R	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pr		3 □Ectopic	pregnancy					ate of deliv	′
the death of the etten or hed for u	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Preç 9☐ Unk	gnant at time nown	of death	5 Other (specify)					NOTH	Day Year
ga at the gard	2	Part II. Other significant conditio	ns contributing to	death but no	ot resulting in th	e underlying	cause give	n in Part	l.	1	obacco use co		the cause of death?
w requi	eted									24a. Was			
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Of V Physic r this ce ral dire	0	1 ☐ Yes 2 ☑ No			2 FR/Outpa			4 🗆 141		me 5 Resid			fy)
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r Attending or death. rector: Afte by the fune	Certification;	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Plac	ce of Injury -	At home, farm					28f. Location (S City or Tox		nber or Rur	al Route Number,
urs eft rel Di									1				
To the Hospitel or Attending Physician: The I within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical			basis of exa	mination and/o	or investigation	on, in my op	oinion, dea	ath occur	red at the time,	date and place	a, and due t	to the cause(s)
To the comp	×	29b. Signature and title of certifier	/.			2	9c. License	number			29d. Date sign	ned (Month,	Day, Year)
			4				1)2	145			11-6	- 20	0 (
4		30. Name and address of person of ABDEC WHEE	who completed car	use of death	(Item 23a) (Ty	pe, Print)	10 A	VE.	HAG	BRITER	Ir. M	02	1742
State Registra		31. Date filed (Month, Day, Year)	3 2006 32.	Registrar's	Signature	Coerts	1						

06-08402 Paul Anderson

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006	3	6	1	2	-
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Medical Examiner A A A A A A A A A	ntry) MD
Harbor Hospital Baltimore City N/A Funeral Director Funeral Director Funeral Director Funeral Director Aur way 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ntry) MD
Director 219.52.9507 12M 2 Foreign Coun 10c. City. Town or Location 10d. State 10b. County 10c. City. Town or Location 10d. State 10d. State 10d. State 10d. County 10d. City. Town or Location 10d. State 10d. State 10d. County 10d. City. Town or Location 10d. State 10d. State 10d. County 10d. City. Town or Location 10d. Ci	ntry) MD
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11. Marital Status 1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced If Yes, Give Year or Or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 Namital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced If Yes, Give Year or Or Dates: 1 Specify: 1 No speci	1 Xyes 2 No
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To Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Int United St Postal Ser	an Indian, Black,
18 Mother's Name (First, Middle, Last)	ates Vice
Supervisor Postal Ser	k.
Program C. Anderson / Wife 1216 E. Belvedene Avenue Balto. M	D 21239
E A g E E 4 Donation 5 Other Specify: OWITSON OTO	ilb, MD
The standard of Fineral Service Leedsee 21. Signature of Fineral Service Leedsee 22. Name and Address of Facility Vaughn C. Greene Funeral Services 4905 York Load Batto. MD 21212	
Physician /Medical xaminer 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease or condition resulting in death) b. Sequentially list conditions,	Approximate Interval Between Onset and Death
if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
Description of the property of	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probate	
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The state of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other	
To spital 1 Inpatient 2 FR/Outpatient 3 DOA Offer 4 Nursing Home 5 Residence 6 Other: 1 Ves 2 No 128a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred	
Volume 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 1 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural or Town, State)	l Route Number, City
	cause(s)
O.C.M.E. November 7, 2006	
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month) (Pay, Year) 7 2006 32. Registrar's Signature Registrar	

State of Maryland / Department of Health and Mental Hygiene [] [] 6

36427 1 - For State Registrar Certificate of Death Rag. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 1:27_ 2006 George Adams 11 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BaltiMorp osedale gillave If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb.11,1927 If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Min. Months Davs Hours 1 XM 2 ☐ F Director 404-28-1502 79 Kentucky Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County or 28a-f show other traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2X No Baltimore Director Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 39 Terrace Road or Itema 23a 21221 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2X Married 1 Tyes 2 □ No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: White þ lf Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry perunt. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other fraumatic months. Elementary/Secondary (0-12) College (1-4or 5+) Beth Steel Steel Worker 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Johnny Adams Beuliah Holbrook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Flora Adams / wife 39 Terrace Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Cemetery 11/16/06Baltimore MD 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee aur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Facture **Physician** /Medical Due to (or as a consequence of): Examiner Septic Snock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit ESRD Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Schemic Cardiomy opathy 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 🎉 No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending PI
 24 hours after death.
 Funeral Director: After the Certification; 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number lscher ND 11/12/06 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -Scher 9000 Franklin Square Hoel 32. Registrar's Signature State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 10, 2006 10:10 AM Elvira Meis Abraham /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery Hospice Casey House Rockville 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🖾 F Yrs. 91 212-47-2398 February 21, 1915 Argentina Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10b. County or Iteme 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Montgomery Village Maryland Montgomery Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20886 19315 Club House Road, Apt. 103 Argentina by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1XYes 2□No Specify: Argentinean Specify: White 3X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 4 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H tant: If Item 27 is marked off jury or other treumatic even Manuel Meis Rosario Britos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nilda R. Abraham / Daughter 19315 Club House Road, Apt. 103, Montgomery Village, MD. 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 16, 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. 2006 Montgomery Crematorium, Inc Bethesda, Maryland 21. Signature of Funerat Service-Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 Sugarette ! Samo 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ovarian Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificete has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🛛 No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify)Hospice Hospital: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

31. Date filed (Month, Day, Year) NOV 1 7 Registrar

Cynthia M. Williams, D.O. 32. Registrar's Signature

Cepthia M Williams Do

November 10, 2006

H0058032

P.O. Box 68760,

Records.

			State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Amend Item 23a per dr., C861 11/1/06dbb Reg. No. Reg. No.	36429
	Physici	an	Month Day Year	3. Time of Death
	/Medio	cal	WARRINGTON BROWN NOW Town or Leasting of Death	B
1		,	NERTHENEST HOSPITAL CENTER PHUDALISTOWN BALTIMORE	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 Months Days Hours Min. 4 Month, Day, Year 1 Month, Day, Year 1 Month Day 1 Min. 4	yland
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	th with the 23s or 28	Funeral Director	10e. Street and Number 10g. Citizen of What Country 4800 Yellowwood Rd. \$519 21209 USA	n
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturat", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evant retimatible rediffications.	by Funer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give 1 Yes 2 No Specify: 1 Never Married 2 No Specify:	
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Maryland	should be file and Mental Hy marked oth	To Be	17. Father's Name (First, Middle, Last)	
	1 and 2 sho Health and Iam 27 ts mu		19a. Informant's Name/Relationship (Type, Print Granddougher) 1300 Pennsylvania Ave \$3 Balto. N	ld.21217
Baltimore,	Pages 1 nent of He ant: If itan ury or oth		20a. Method of Disposition 1 Aburial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town Carrison Forest 1 (21/2006) Dwings Mi	lls, Md.
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee Public Published Licensee 22. Name and Address of Facility Joseph L. Russ Funeral, Home, P. A. 2222 W. North Ave. Balto. Md. 212	ib
	Physician		shock, or heart failure. List only one cause on each line.	pproximate iterval Between inset and Death
	/Medical Examiner		Due to (or as a consequence of: Aspiration Pneumonia	
V	cuted nd rransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events c.	
8760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence of): d.	
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ıy Year
Q	uires that n signed b	by	Part III. Other significant contributing to death but not resulting in the underlying cause given in Fact.	
Records,	The law requir te has been si page 2 should	Completed	this tony of Brain Turner, Status past left 24a. Was an autopsy performed? death?	letion of cause of
Vital	(0	Be Co	25. Was case referred to medical 26. Place of Death (Check only one)	→ No
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	To th within To th compl	Me	29c. License number 29d. Date signed (Month, Day	
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	Sta Registr		31. Date filed (Month, Day, Year)	

		For State Registrar	State of Marylar		artment of F rtificate of		lental Hygie		36430
		Decedent's Name (First, Middle, Landson L	ast)				2. Date of Death		3. Time of Death
Physic		Dylan Isiah Bul	lano	•			Novembe	Day Year	11:00AM
/Medi Examii		4a. Facility Name (If not institution, gi			4b. City, Town, o	r Location of Death		4c. County of Dea	
		The Tohns Ho	okins Hose	ital	Baltim	ore city	1	N/A	
Funeral			Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) 9. Bit	thplace (State or Foreign ountry)
Director		None	1⊈M 2□F N/A	Yrs.	3		8. Date of Birth (Month, Day, Ye NOV • 8	2006 Ma	ryĺand
and w		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
Mary f sho	ō	Maryland Baltimo	re County Sp	arks					1 ☐ Yes 2XONo
the 28a	Director	10e. Street and Number	2 -1		10f. Zip Code		10g.	Citizen of What C	ountry?
3a ou		12 Far Corners	Court		21152		U	United St	ates
deatt	Funeral	11. Marital Status	12. Was Decedent Ever in U		Was Decedent of H	lispanic Origin? (Sp	ecity Yes or No-	14. Race - Am	
after after		1XXNever Married 2☐ Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 No	an, Mexican, Puerto Specify:	Hican, etc.)	Black, Whi	
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d be antal	To Be	Anthony Bullanc					ney Kuczyn	· ·	
tally ideal of the Maryland 2 should be filed within 72 hours after death with the Maryland and Mental hygiene. Is marked other then "natural", or Items 23a or 28a-f show eumatic event, the Medical Examinar must be notified at	-	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street		al Route Number, Ci		Zip Code)
olth a		Mr. Anthony Bull	ano (Father)	12	Far Corne	rs Court,	Sarks,	Maryland	21152
S 1 a 1 a 1 a 1 a 1 a 1 a 1 a 1 a 1 a 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		Place of Dispo	osition (Name of matory or other place	(9)	Dat 13 200	. Location - City or	Town, State
Page nent ent: if		4 □ Donation 5 □ Other (Spec		ans Fu	neral Cha	pel Nov.	11, 2006	Forest H	ill, Md.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinations in political and once.		21. Signature of Funeral Service Lice	ensee L	Pi Pi	2. Name and Addre eaceful A 325 York	ss of Facility Iternativ Road Tim	es Funera onium, Ma	1&Cremat	ion Ctr.P.A.
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/Medical		resulting in death)	a. Due to (or as a consec		14		-		SHICHT
Examiner		Sequentially list conditions,	b						
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leath certific attending p	M.	IF FEMALE:	23c. If yes, outcome of pregn	ancy				23d. Date of de	liveo
atter d for c	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3	☐Ectopic pregnancy ☐ Other (specify)	·		Month Month	Day Year
thet the de	hyslcian/Me	9 Unknown	9□ Unknown		,,,,,,				
es the igned t	by P	Part II. Other significant conditions	contributing to death but not res	sulting in the u	ınderlying cause gıv	en in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
w require		renal failure					1 🗆 Yes	2 12No 3 □ P	robably 4 Unknown
e law requ	piet	anasarca					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	Completed	disseminated	intravascul	Or CO	mulatu	m	1 Ves 2 □	death?	
Physician: Th r this certificate ral director, pag	Be (25. Was case referred to medical examiner?			J		Check only one		-
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after Direct	Certification;	4 Homicide determined	building, etc. (Speci	fy)	reet, ractory, onice		City or Town, S	tate)	urai noute Number,
spita Jours neral		29a. Certifying P	hysician: To the best of my know	owledge, deat	h occurred at the tin	ne, date and place,	and due to the cause	e(s) and manner a	s stated.
To the Hospital or Attending Within 24 hours after death. To the Funeral Director: Attence Completely filled in by the fune	edicai	(Check only one) 2 Medical Exa	miner: On the basis of examination and manner stated.	ation and/or in	vestigation, in my o	pinion, death occurr	red at the time, date	and place, and due	to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	AllA.	^	29c. Licens			Date signed (Mon.	
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l	1	30. Name and address person	completed caus death (Ite	1		W 15 0			
C+	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature (o)	JU NOTH	WOLLED	t. Baltima	DIE MD	21287
Regist		NUV1 7 2	006		1246.3				
OHMH 17 Rev 1/2	001		1.9 3.30.000	Care Earl		0.00			

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) James Horner Ball, Sr. 4a. Facility Name (If not institution, give street and number) Carroll Hospital Center 5. Social Security Number 219-32-9117 VIX.M. 2 F 84 Yrs. 4b. City, Town, or Location of Death Westminster Tunder 1 Year If Under 24 Hrs. Month, Day, Yester Month, Day, Yester Month, Day Month, Day Month, Day, Yester Month, Day, Yester Month, Day Month, Day Month, Day, Yester MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. 328 Estate Rd. 21136 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? VIX.M. 2 F Named Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Day Year 3. Time of Death 6:30 A M 4c. Country of Death Carroll 19. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes XXNo Citizen of What Country? U.S.A. 14. Race American Indian, Black, White, etc. Specify: White Kind of Business/Industry Education
Au	Ac. County of Death Carroll 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes XXNO Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry
4a. Facility Name (If not institution, give street and number) Carroll Hospital Center Funeral Director 5. Social Security Number 219-32-9117 XXM 2 F 84 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Baltimore Reisterstown 10c. Street and Number 328 Estate Rd. 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? Vestminster Vestminster If Under 14 Hrs. Westminster If Under 14 Hrs. Months Days Hours Min. Sep. 5, 10c. City, Town or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Town, or Location 10c. City, Tow	Carroll 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1□Yes XXNo Citizen of What Country? U.S.A. 14. Race · American Indian, Black, White, etc. Specify: White Kind of Business/Industry
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328 Estate Rd. 21136 11. Marital Status 1	14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry
11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? X[X] Yes 2 No If Yes, Give Year or Dates: WW II 12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Was Decedent of Hispanic Origin? (Specify Origin) 14. Was Decedent of Hispanic Origin? (Specify Origin) 14. Was Decedent of Hispanic Origin? (Specify Origin) 14. Was Decedent of Hispanic Origin? (Specify Origin) 14. Was Decedent of Hispanic Origin? (Specify Origin) 14. Was Decedent of Hispanic Origin? (Specify Origin) 14. Was Decedent of Hispanic Origin? (Specify	Black, White, etc. Specify: White Kind of Business/Industry
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들 중 모 트 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Ci	
Stephen Kottler Ball / Son 1300 Woodridge Lane; Elder	
20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cematery, crematory or other place) Evergreen	Location - City or Town, State
A Donation 5 Other (Specify) Evergreen Evergreen 11/18/06 F	inksburg, MD
20a. Method of Disposition XXBurial 2 Cremation 3 Chemoval from State Light and Ligh	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition resulting in death) (Modical	one day
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O = 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 23e. Did tobacc	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc	o use contribute to the cause of death? 2 □ No 3 ☑ Probably 4 □ Unknown
D D D D D D D D D D D D D D D D D D D	24b. Were autopsy findings available
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The state of Death (Check only one) 25. Was case referred to medical examiner?	10 105 20110
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence R	
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how in Injury 28d. Describe how in Injury 28d. Describe how in Injury 28d. Describe how in Injury 28d. Describe how in Injury 28d. Describe how in Injury 31 Yes 2 No	jury occurred
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28d. Describe how in 28d. Desc	ite)
To the first of th	(s) and manner as stated. and place, and due to the cause(s)
	Date signed (Month, Day, Year)
1100 mb 133184 No	vernh 15, 2006
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Time then Rishner II 4 Businers (AH DOW RISH	3 1mm, MD 24136
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrer 36432 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month NOV. **Physician** 2:30 p M Lawrence Eugene Brubaker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reisterstown Baltimore 21 Stocksdale Ave. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
Dec. 10, 1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1]ØM 2□F Missouri 705-10-6257 92 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State ehow rthan *natural', or itame 23a or 28e-1 ehov the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Reisterstown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 U.S.A. 21 Stocksdale Ave. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hardware Store Salesman of Health and Mental Hygie fitam 27 is marked other t r other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Harvey L. Brubaker Ruby Mae Pratt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a Faye Stone - grand daughter 21 Stocksdalle Ave., Reisterstown, Md. 21136 Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 0 1 □ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of important: If eny injury or once. All Saints Cem. Nov. 18,2006 Reisterstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. J. Hatt Pel 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Scherns all Pnysician Advance /Medical Due to (or as a consequence ...). **Examiner** ASUN Sequentially list conditions, 1 a.y., eaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as the l IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ COL CIA 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No ai or Attending Physicien: T s after death. i Director: After this certificate funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No. 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1. Natural 5 Pending 1 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a the Hospital filled Certifying Physician. To the best of my knowledge, death scurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/of exercised in the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 1737949 death em 23a) (Type, Print) 2457 30. Name and address of person who od cause o 31. Date filed (Month, Day, Year) ist hem Z State Registrar MOA 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 16th oseph City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Howard columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 145.10.4142 88 Dec 22, 1917 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes ŽĀNo Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5030 Dorsey Hall Dr 21042 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. No. 1 Yes 2 No. 11 Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eberhardt Beitz Lena Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5030 Dorsey Hall Dr, Ellicott City, MD 21042 Madeline Beitz 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UNIL 20c. Location - City or Town, State Lakeview Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Cinnaminson, NJ

Physician /Medical Examiner

Physician

/Medical

Examiner

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permit. Pages 1 and 2 should be filled v Department of Heelth and Mental Hygien important: If item 27 is marked other th any injury or other traumatic svent, that once.

with the Maryland

death v

filed within 72 hours after

Baltimore, Maryland 21215-0036

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Ye the Funeral Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760.

	K. Gregory Kink	MO1148 Fink Funeral Home, P.A. 426 Crain Hwy S, Glen Burnie, MD 21061	
	shock or heart failure. List only	plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, age cause on each line.	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	cardiango patty	
	resulting in death)	Due to (or as a consequence of):	
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completed by injertial medical Examined	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 II ive birth 2 1 Fetal death 3 Fetanic pregnancy	ite of delivery onth Day Year
-	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use containing in the underlying cause given in Part I.	tribute to the cause of death? 3 ☐ Probably 4 ☑Unknown
		performed2	Were autopsy findings available prior to completion of cause of
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	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No	death? 1 ☐ Yes 2 ☐ No ner (Specify)
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DHMH 17 Rev 1/2001

Registrar

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2006

31. Date filed (Month, Day, Year)

5005

Bell Lane claringuelle MD 21029

			For State Registrar	State of Ma	ryland	d / Depa <i>Cer</i>	artme tifica	nt of H <i>te of L</i>	ealth Death	and M	lental		eng ()	06	36434
			Decedent's Name (First, Middle, Last)								2. Date	of Death		V	3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City	, Town, or	Location	of Death			4c. County	y of Death	
			Joseph Ritchie H	ospice			Ba	ltimo	re				1	A\v	
	Funeral		Social Security Number 6. Sex		(In yrs. la	ast birthday)	tf Unde	or 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date (of Birth	rear)	9. Birth	place (State or Foreign ntry)
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	the h	Director	10e. Street and Number	F4		Darti		ip Code				100	g. Citizen of	What Cou	ntry?
	with with		1218 Cleveland	Street			1,02	212	30				USA		,
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. The marked other than "naturel", or Iteme 23a or 28a-f show filer traumatic event, the Medical Examinar must be notified at	by Funerai		2. Was Decedent E	ver in U.S	3. 13. V	Vas Dece	edent of Hi		igin? (Spe	ecify Yes	or No-		ce - Ameri	can Indian,
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altimore,	of H if ite		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □R	emoval from State	Ce	metery, cren	natory or	other place	9)		Date		oc. Location	•	
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Bail	permit. Pages Department of the Important: if ite eny injury or of once.		21. Signature of Funeral Service License	one	,	22	. Name a	ind Addres	s of Facili	ity MAF	CH F	UNER	AL HOM	IE-EA	ST
	do z e d	_	7		the death								more,	MD	21202 Approximate
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	/Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):									
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687	phys s the	dical	0												
_	that the death certificed by the attending posterior detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of	of pregnar	псу							23d. Da	ite of detive	erv
.О. Вох	atter	ciar	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 4 ☐ Pregnant at t			Ectopic Other (s	pecify)						onth	Day Year
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J.	res that igned b be deta	y PI	Part II. Other significant conditions con	tributing to death bu	t not resu	lting in the ur	nderlying	cause give	n in Part I	l.	23e.	Did toba	cco use con	tribute to t	he cause of death?
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<u>a</u>	ysician: The is certificate hadirector, page	a	25. Was case referred to medical						26 Place	e of Death	1 TY		J'No	T L Yes	2U NO
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<u>o</u>	After S After	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day	rear)	Intury	м	Work 1 □ Y	r ∕es 2 🗆	No					
Division of Vital Records,	Attending or death. ector: After by the funer	ill ill ill ill ill ill ill ill ill ill	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of triju	ry - At hor	me, farm, stre	et, facto	ry, office				on (Stre		oer or Rura	al Route Number,
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	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a Certifier 1 Certifying Physical Check only 2 Medical Examin	er: On the basis of	examinati	vladga death ion and/or inv	estigatio	d at the tim n, in my op	e data ar pinion, dea	nd place :	and dua to ed at the t	the cau	ea(e) and ni e and place,	and due to	tMad. o the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		Ce	rtificate of	Death	Reg	2006	36435
	Physici	an	1. Decedent's Name (First, Middle, L		Dor mo	- n		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Differey	argaret	Bowma		Landing (Dark)	November		
1	Examin	ier	4a. Facility Name (If not institution, g Union Memorial			Baltir	r Location of Death		4c. County of Deat	n
-	Funeral			Sex 7. Age (In yrs.	. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Rirt	hplace (State or Foreign
	Director		215-32-5346	1□M 2 x F 71	Yrs.	Months Days	Hours Min.	(Month, Day, Y 5 20	1935	MD MD
	put *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
	f shored	ō	MD N/A		Baltir					1 XYes 2 No
	the N 28a-	rect	10e. Street and Number		241611	10f. Zip Code		10g	g. Citizen of What Co	untry?
	h with	Funeral Director	1827 E. 33rd	Street		Ba:	ltimore		USA	
	ems?	ıner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
20	72 hours after death with the Maryland natural", or items 23a or 28a-f show dival Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 👿 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	Black
2-003p	hour tural		15. Decedent's	Education		edent's Usual Occup		16	6b. Kind of Business/	
ر د اع	hin 72 e. an "na Medic	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	e kind of work done DO NOT use retired	during most of work d)	ring		
7	er the	Son	12th	N/A	I	Head Cook			Villa Ma	ria
	be file	Be	17. Father's Name (First, Middle, La	st) Crawley		}		e (First, Middle, Ma abeth		iggers
<u> </u>	12 should be filed within h and Mental Hygiene. 7 is marked other than "fraumatic event, the Mec	2	Wilton 19a. Informant's Name/Relationship		19h Mail	ing Address (Street			City or Town, State, 2	
<u> </u>	nd 2 si Ith an 27 is r traus		Charles Bowman-h			27 E. 33rd		-		218
ā,	s 1 ar if Hea item 3		20a. Method of Disposition	20b.	Place of Diso	osition (Name of ematory or other place	i		oc. Location - City or	Town, State
Ē	Pages nent of h ant; If ite ury or of		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			n Forest V		2/2006	Owings Mi	lls MD
baitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	ensee) ²	2. Name and Addre	, M	ARCH FUNE nue Balti	RAL HOME-I	EAST 21202
			23a. Part1. Enter the disease, or co	emplications that caused the dea	th. Do not er				-	Approximate Interval Between
	Physician		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each line.	138h	a Dis	eane			Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consecutive consecutiv	quence of):	1				
	Examiner		Sequentially list conditions	b. Drabel	Co.					
7	pe tis	iner	Sequentially list conditions, if any leading to lime dialecause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	uence of):					
	and and Il-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):	<u> </u>				
09/90	certificate be executed ding physician and se as the burial-transit	i E		1º engle	ral 1	Simlar	- Abs	ine		
00	ertificate ing phy e as the	Medical								
. DOX	death cer e attendin d for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome pf pregn 1 Live birth 2 Fet 4 Pregnant at time of	al death 3	□Ectopic pregnancy □ Other <i>(sp</i> ec <i>ify)</i> _	/		23d. Date of deli Month	ivery Day Year
л Э	at the by the	hys	9 ☐ Unknown	9□Unknown				Tari Buu		
recoras, I	quires the n signed ild be de	þ	Part II. Other significant conditions	contributing to death but not res	sulting in the u	underlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to	obably 4 Unknown
S	aw red	Completed	Degens	In Jont	. Du	serse		24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
ř	The ate has	mo	Stalls perd	1 bill as	no h	nee compr	Nata	performe 1 Yes 2 ☑	ed2 death?	2 □ No
VII	clan: ertifica	Be C	25. Was case referred to medical examiner?			- lau		h (Check only one)		
20	hysic this o	유	1 ☑ Yes 2 ☐ No		 	nt 3 DOA Oth	4 Li Nursing Ho		ce 6 Other (Spec	cify)
	aling F	ion:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yai k? Yes 2∐No	28d. Describe how	injury occurred	
VISION	Attender death	fical	3 Suicide 6 Could not	be 28e. Place of injury - At h	l jome, farm, si			28f. Location (Stree	et and Number or Ru	ıral Route Number,
5	al or safter	Certification:	4 ☐ Homicide determine	building, etc. (Speci	ny)			City or Town,	State)	
	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Funeral Director After this certificate has been signed by the attendiction of the funeral director, page 2 should be detached for use	Medical (Physician: To the best of my kn aminer: On the basis of examin and manner stated.						
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licens		, ,	d. Date signed (Month	
)	,		> Serve	W MD		D 3	(414		11/14/0	<u> </u>
	4		30. Name and address of person wh	o completed cause of death (Ite-	m 23a) (Type	, Print)	c + -	C 170		3.2
			31. Date filed (Months Day Year)	2006 32 Registrar's Sign	ature:	JL WATE	trule 50	3 12/1CT1	more m	11) <1<01
	Sta Registr		MUV I	2006 32. Registrar's Sign	3.6° 80	- S- N				

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 11 4:43 **Physician** Bennett Frances Lee 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Good Samaritan Hospital Baltimore ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. 7 28 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 62 Yrs. 133-34-0380 N.C Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location iral', or itams 23a or 28a-f ahor Examiner must be notified at 1 XYes 2 No Director N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21206 5303 Valiquet Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itam any injury or other traumatic avant, the Medical Equator. Black, White, etc. 1 Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black ğ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Colfege (1-4or 5+) Elementary/Secondary (0-12) N/A 8th unemployed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gilbert McLaughlin Flora Beatrice Leslie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5303 Valiquet Avenue Baltimore, MD Laura Simmons-sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 13□ Burial 2 □ Cremation 3 □ Removal from State Mt. Carmel Cemetery 11/18/2006 MD Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARCH_FUNERAL HOME-EAST 21. Signature of Funeral Service Licensee Waner 1101 E. North Avenue Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, CONGESTIVE HEART FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed END STAGE RENAL DISEASE ON HEMODIALYSIS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 1 No Division of Vital 25. Was case referred to medical 26. Place of Death [Check only one] Be examiner? Hospital: 1 Ampatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: injury 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident 6 Could not be determined 3 C Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗀 Homicide Hospital of 24 hours af a Funerel D (a) Contifying Physician: To the best of my knowledge, death conumed at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061789 Ston Awtel, NO NOVEMBER, 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LORRAINE OFORI-AWVAH, 5601 LOCH RAYEN BLVD. BALTIMORE, 21239. GOSHL) 31. Date filed (Ment) Pay, Year 2006 32 Registrar's Signature State 5 Block Registrar

ANC

State of Maryland / Department of Health and Mental Hygiene 2006 36437 For State Registre Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 1:14 P M Marguerite E. Burrell November 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Shady Grove Adventist Hospital Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🖾 F 89 Yrs. Director 066-10-4492 March 3, 1917 New York Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Worle** r than "natural", or iteme 23a or 28a-f ehov the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? With 3120 Birchtree Lane 20906 United States Funerai death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 □ Never Married 2 □ Married ☐Yes 2⊠No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates: Specify: Specify: ğ White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene ant: if item 27 is marked other than ury or other traumatic event, the Mery or other traumatic event, the Mery or other traumatic event, the Mery or other traumatic event, the Mery or other traumatic event, the Mery or other traumatic event, the Mery or other traumatic event, the Mery or other traumatic event, the Mery or other traumatic event. Medical Records Administrator Health Care 2 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Be Denis Donahue Nora Hartnett ဨ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Pfleiderer / Daughter 3120 Birchtree Lane, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery
Crematorium Inc. November 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of Himportant: if ite eny injury or ot once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 16, 2006 Bethesda, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Days Immediate Cause (Final disease or condition Pneumonia **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis 2 Days Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consuluence of): Examine The law requires that the death certificate be executed burial-transit 2 Days Atrial Fibrillation resulting in death) Last Due to (or as a consequence of) Box 68760. physicien Physician/Medical 9 use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy Day Year ò in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. | signed by the a d be detached f 1 ☐ Yes 2 🖾 No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ of Vital Records, Recent Stroke 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificete has l director, page 2 s autopsy performed? 1 ☐ Yes 2⊠ No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: Medicai Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral dir this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 1 DNatural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident efter death Director: the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide ò within 24 hours ef To the Funeral D completely filled in Hospitai 29a. Certifiei 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D64444 November 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Arijit Dasgupt M.D. 890 Medical Drive, Gaithersburg, Maryland 20877 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

06-08560 Barry Butler

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 36438

		1- For State Registrar		Cer	tificate of	Death			R	teg. No.	00 0040
Physicia	ian/ 1. Decedent's Name (First, Middle,Last)									ath Day Year	3. Time of Death
edical Examii	ner	Barry Butle							Month Novembe		1600 hrs
		4a. Facility Name (if not institute John Hopkins Bayvie			4	b. City, Town Baltimor		n of Death	1	4c. County of D	eath
	Щ,	<u> </u>	6. Sex	7. Age (In yrs. Ia	et hirthday)	If Under 1		nder 24Hrs	8 Date of Bu	rth(MM/DD/YYYY) 9	Buthplace (State or
Funeral Director		5. Social Security Number	1 X M 2 F	7. Age (III yrs. Ia	52 Yrs.	Months	Days Ho			Fo	country) SC
è	ŀ	Usual Residence of Decedent 10a. State 10b. Count	lv	10c. City.	Town or Locati	on					10d Inside City Limits
eath with the Maryland items 23a or 28a-f show any ust he notified at once.	٦		York		lew York						1 XYes 2 No
Maryla 28a-f	recto	10e. Street and Number				10f. Zip Co				10g. Citizen of What	
th the 23a or		22 East 108th		edent Ever in U	C 112 M/o	1002		rigin? / Ci	pecify Yes or No	United	merican Indian, Black,
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene int: If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once	Funeral Director	11. Marital Status 1 X Never Married 2	Married Armed Fo		If Y	es, specify Ci	ıban, Mexic	an, Puerto		White, et	tc.
after	by F		Divorced If Yes, Give Yea or Dates:			Yes 2X				Specify:	Black
hours natur	E G	 Decedent's Education (Specific Elementary/Secondary (0-12) 			16a. Deceden during mo	t's Usual Occ ost of working				16b. Kind of Busine	ess/Industry
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene fant: If iten 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12	1	40101)	Cc	onstru	ction	Work	er	Const	ruction
5-0(led wi Hygier other		17. Father's Name (First, Midd	lle, Last)							Maiden Surname)	
21215-0036 and be filed within 7 Mental Hygiene marked other than c event, the Me it a	o Be	unk 19a. Informant's Name/Relatio	nahin (Tuna Brint)		10b Mailing	Addross (6			Butler	mber, City or Town, S	State Zin Code)
Jre, MD 21215-003 s I and 2 should be filed within of Health and Mental Hygiene If iten 27 is marked other the her traumatic event, the Me.	ř	Charlene Fyal				,				York, NY	
e, h. l and Health		20a. Method of Disposition 1 X Burial 2 Cremati			Place of Dispos crematory or oth		f cemetery,		Date	20c. Location - Cit	y or Town, State
MOI Pages nent of ant: I		4 Donation 5 Other	Specify:		est Gre		metery	7 11			, New Jersey
Baltimore, permit Pages I ar Department of He Important: If ite	1	21. Signature of uneral Servin	ce Licensee M	01113		lame and Add				rtiz Fune: ew York, N	cal Home, Inc. NY 10029
Physician	9	23a. Part I. Enter the disease,	or complications that c	aused the death.	Do not enter th	ne mode of d					Approximate Interval
/Medical	3 57	failure. List only one cause Immediate Cause (Final disea		ntracerebr le cocain c			toxica	tion-			Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a	consequence of	f).						
	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of	f):						
4	Examine	cause. Enter Underlying Caus (Disease or injury that initiated	d C.	consequence of	f):						
nd Lansit		events resulting in death) Las	d						4		
frate be executed g physician and street transit	edical	X UNPENDED	X AMENDED	#23a,PII #23a,27,2	.,2/,28a- 28a-f, per	t, penyl rME, g86	5, g864 52, 12/	, 2/21 11/06	1/0/ TT TT		
760 ficate b	Σ	IF FEMALE: 23b. Was decedent pregnant in		outcome of pregi	nancy					23d. Date of del Month	ivery Day Year
		past 12 months?	4 Pregr	ant at time of de	oth	tar death her (S <i>pecify</i>)		ple pregn	aricy	World	Day Toal
Bo ne deat the at	Physicia		Jnknown g Unknown					0-41	22a Did	tabasas usa santribut	e to the cause of death?
P.O. Box 68 s that the death certigened by the attending edetached for use as	by F	Part II. Other significant con- Intravenous dr	5	o death but not re	esuiting in the u	inderlying ca	ise given in	Part I.			Probably 4 V Unknown
dS, I	ted	Hitlavalous ul	ug ususe				-		24a. Was		e autopsy findings available
of Vital Records, ig Physician: The law require the true this certificate has been some all director, page 2 should be	Completed				<u> </u>					ormed? deat	
Vital Rec		25. Was case referred to medi	ical			26 F	Place of Dea	th (Check	1 Yes	2 No 1	Yes 2 No
ital sician is cert irecto	a	examiner?	Uital	Inpatient 2	ER/Outpatient		Other ₄		ng Home 5	Residence 6	Other:
n of Vi ling Physi After this funeral dir	: To	1 Yes 2 No 27. Manner of Death	28a. Date (Month		28b. Time of I		Injury at W	ork?	28d. Describe	how injury occurred	
on on ath.	tion		ending		unknown	1	Yes 2	No X	unknown		
Division tal or Attendi rs after death. al Director: A led in by the fu	Certification:			e of Injury - At he		et, factory, of	ice building	etc.	28f. Location or Town,	(Street and Number of State) 5675 0 D	r Rural Route Number, City
Spital	Cert	4 Homicide	(Specify)	1 Column		_			Bultimore	ND	
Division To the Hospital or Attendition within 24 hours after death To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying one) 2 Medical E	Physician: To the bear examiner:On the basis	of examination a	ge, death occur ind/or investigat	red at the tim tion, in my op	e, date and inion, death	place, and occurred	d due to the cau at the time, date	ise(s) and manner as and place, and due	started. to the cause(s)
To wit To	Mec	29b. Signature and title of cert	and manner s	stated			cense numb				(Month, Day, Year)
		Santt Fruitte	all un			C	.C.M.E.			November 12	, 2006
		30. Name and address of pers				4 D		line = -	MD 04004	•	
		Pamela E. Southall,		Medical Exa		1 Penn St	reet, Bal	umbre,	MD 21201		
St	tate	31. Date filed (Month, Day, Yea	7 2406 32.	egistrar's Signatu	L L	1 Bur					

06-08486 Harvin Ernie Banks

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006	36	43	0
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	1- For State Certificate of Death								. No.	JO 3040.
Physicia Medical Examin	n/ ier	1. Decedent's Name (First, Middle,Last) HARVIN ERNIE BA	NKS					Date of Death Month [November 8	Day Year	3. Time of Death 0217 hrs
Mar Markey		4a. Facility Name (if not institution, give street				City, Town, or Loca		101011100110	4c County of E	Death
Funeral		Johns Hopkins Hospital 5. Social Security Number 6. Sex	7. Age (In y	rs last birti		Saltimore f Under 1 Year If	Under 24Hrs 8	B. Date of Birth	N/A	Birthplace (State or
Director		215-70-6756 XXM 2					lours Min.	07/26/	F	oreign Country) MD .
any	ı	10a. State 10b. County	10c. (City, Town	or Location		-			10d Inside City Limits
daryland 28a-f show 1 at once.	ğ	MD. N/A		Ba1	timo					1XX Yes 2 No
oith the Maryland , 23a or 28a-f show	Funeral Director	10e Street and Number	\		10	Of. Zip Code		10g	Citizen of What U.S	
with the ns 23a	曺		as Decedent Ever in	n U.S.	13. Was D	21217 ecedent of Hispania	Origin? (Speci	fy Yes or No-	14. Race - A	merican Indian, 8lack,
	by Fune	I Nevel Married 2 42 2 Married 1	rmed Forces? Yes 2XX N Give Year	0		specify Cuban, Me: $2\overline{XX}$ No spe		an, etc.)	White, e	Black
hours a	8	15. Decedent's Education (Specify only high	est grade completed			Jsual Occupation (of working life. DO			6b. Kind of Busin	ess/Industry
17215-0036 Id be filed within 72 hours aft fental Hygiene narked other than "natural" event, the Medical Examine	Completed	Elementary/Secondary (0-12) Co	llege (1-4 or 5+)	Dom	esti	c Engin	eer	8	Self Emp	nloved
5-00 led with Hygien offier the Me		17. Father's Name (First, Middle, Last)		POI	ICSTI	18.M	other's Name (Fi	rst, Middle, Ma		proyec
D 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medica	쵥	Samuel Gillyard 19a. Informant's Name/Relationship (Type, Pr	int \	I 10h	Mailing Ac	Ma:	ry Banl		or City or Town	State Zin Code)
and 2 shoul lealth and N tem 27 is in traumatic		Andrew Gillyard (cott St				1230
Jore, ME ages 1 and 2 sl nt of Health ar t: If item 27 other trauma		20a. Method of Disposition 1 Burial 2 X Cremation 3 Rer			f Disposition bry or other	(Name of cemeter place)			20c. Location - Cit	
	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Lisensee A	M	letro		matory				sville,Md.
Balti permit. Departu Importi injury o		Toud III	25/0	A	1130	tep Bro Cep Eutaw	Place	,Balti	more, Mo	d. 21217
Physician /Medical		23a. Part 1. Enter the disease, or complication failure. List only one cause on each line	s that caused the de	an. Do no	t enter the n	node of dying, such	as cardiac or re	spiratory arrest	t, shock, or heart	Approximate Interval 8etween Onset and
Examiner			ertensive ca		ascular	disease_				Death
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		cause. Enter Underlying Cause	or as a consequenc	,						
uted id ansit		events resulting in death) Last Due to d.	or as a consequenc	ce of):						
760, Toate be executed sphysician and the burial - transit	n/Medical	XUNPENDED AME	NDED #23a.P	IT.27.1	erME.	g862. 12/11	/06 TT			
3760 ficate l	/We	3b. Was decedent pregnant in the	If yes, outcome of p	regnancy	7-1111to				23d Date of del Month	ivery Day Year
Box 68760, e death certificate bethe attending physical for use as the bu	Physiciar	14	Pregnant at time of			(Specify)	sopio progriancy	1	l	Day
J. Bo t the dea by the a	Ę.	1 Yes 2 No 9 Unknown 9 Part II. Other significant conditions contrib	Unknown	ot resulting	in the unde	dvino cause diven	in Part I	23e Did toba	acco use contribut	e to the cause of death?
ries that the signed by		Fatty Liver	daing to doday pat in	or resulting	in the direc	nying saase given	art art.			Probably 4 Unknown
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Vital Relysician: The sysician: The his certificate director, page	Bec	25. Was case referred to medical examiner?					eath (Check only	one)		
f Vit Physic er this	와	1 ✓ Yes 2 No	1 Inpatient 2		itpatient 3	DOA Othe	- I tursing it		w injury occurred	Other:
on of sending Ph ath.	Ē	1 X Natural 5 Pending	(Month, Day, Year)	202.	into or injur	1 Yes		2 2000 100	i injury occurred	
Division of Vital Records, P.O. 44 hours after death. Finneral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detected.	Certification:	Suicide Could not be	e. Place of Injury - A	At home, fa	rm, street, fa	actory, office building	ig, etc. 28f	Location (Street		r Rural Route Number, City
Divi	5	- Homicide	(pecify)							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit.	Medical	(Check only pine) 2 Medical Examiner: On the								
H 3 H 3	\$	29b. Signature and title of certifier	anner stated			29c. License nur	nber	2	9d. Date signed	(Month, Day, Year)
KUPK		Janut Pouthall, MI				O.C.M.E.		1	November 8,	2006
irak		30. Name and address of person who completed Pamela E. Southall, MD Assi	ed cause of death (i stant Medical E		111 F	enn Street, Ba	altimore, MD	21201		
Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's Sign		a	Ast a				
Registr	ar	NOV 1 7 2006	B. 68 862 S	15	ANGA	al some				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 6:01 PM COCHRANE November 13th 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE N 8. Date of Birth (Month, Day, Year) UMMC If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**⊠**M 2□ F 54 Yrs. MD 215-60-0928 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Baltimore 1 Yes 2 □ No traumatic event, the Medical Examiner must be notified MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 2 21206 USA 5005 Truesdale Avenue Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23s 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Black Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Apartment Complex Maintenance Worker Department of Health and Mental Hygis Important: If Item 27 Is marked other! eny Injury or other traumatic event, It once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name First, Middle, Last) Be Cochrane 4ndrew Barbara BACWELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Cochrane/Daughter 4104 Thoroughbred -76/23 Trail :Worth 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐Cremation 3 Removal from State Baltimore MD Arbutus Memorial 11.20.06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Services 4905 York Road Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARRHYTHMIA Physician minute disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner NEUMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ARTERY ORONARY Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed 1□ Yes 2☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TX CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 64611 November 13th 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KWINTKIEWICZ, 22 SOUTH GREEN STREET, BALTIMORE, HARYLANDZIZON th, Day, Year) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 7 Registrar

			For State	State of Ma	rylan				lealth a	and M			000	3	6441
			Registrar 1. Decedent's Name (First, Middle, Las	e)		06	lilica	e or L	Jealii		2. Date of De	Reg. No.		3. T	ime of Death
п	Physici	an	Stowns Andrews	.,		egie	151	1			Novemb	Day	6 20	. 1 1	35 A M
	/Medic		4a. Facility Name (If not institution, give	street and number)	<u> </u>	-gre	4b. City	Town, or	Location of	of Death	VOVETIE		County of D		<u> </u>
1	Examin	er		s Bayrieu	Mod	ical		Ba	1+in		0_				
	Funoral		5. Social Security Number 6. Se	ex / 7. Age	(In yrs.	ast birthday)		r 1 Year	If Under	24 Hrs.	8 Date of Bir	th	9. 1	Birthplace (S	State or Foreign
	Funeral Director		217-09-7355	M 2□F	9	O Yrs.	Months	Days	Hours	Min.	12-4-	1915	5 M	lary1	and
	P		Usual Residence of Decedent		10 50									104.1-	at a constitution
	how		10a. State 10b. County			y, Town or Lo									side City Limits
	88-f	cto	MD N/A	A	Ва	1time									X
	or 2	Funeral Director	10e. Street and Number 12 S. Patterson	Dark Au				ip Code 1231				US	en of What	Country?	
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	er de item	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ∰Yes 2 □ N If Yes, Give Year or Dates:	WWI	I 13.	If Yes, sp	ecify Cuba	in, Mexican	n, Puerto	ecify Yes or No Rican, etc.)		Black, W	hite, etc.	,
36	irs aff	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	U		1 🗆 Yes	21 No	Specity:				_{Specif} ,Wh	1te	
ဗို	tiled within 72 hours after deeth with the Maryland Hyglane. ther then "natural", or iteme 23e or 28e-f ehow ther, the Medical Exacilizational be notified at	pe	15. Decedent's Ed	lucation		16a. Dece	dent's Us	ual Occupa	ation			16b. Kir	nd of Busine	ss/Industry	-
212	hin 7.	Completed	(Specify only highest gra	de completed) College (1-4or 5-	+)	life.	DO NOT	use retired	during mos 1)	I OF WORK		_			-
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g	al Hy t oth	Be (17. Father's Name (First, Middle, Last)	~					18. Mothe	r's Name	(First, Middle	, Maiden :	Sumame)		
<u>la</u>	Ment Ment arked	Tol	Andrew Cegiels	κi							ne Wac				
Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hygiane. Importent: if item 27 is marked other then "natural; or iteme 23s or 28s-f ehow any injury or other treumatic event, the Medical Extended mail be notified at ADEs.		19a. Informant's Name/Relationship (•	,			l Route Numb)
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0	ges it of the if ite or of		20a. Method of Disposition 1 1 Burial 2 □ Cremation 3 □		0	emetery, cre	matory or	other plac	1						
Ħ	t. Pa rtmen rtent: rjury		4 Donation 5 Other (Specify		Hol	y Ros	ary	Cem	. 1	1 - 18	3-2006	Du	indal	k, MI	D
Baltimore,	Depermine Depermine Important ir mportant		21. Signature of Funeral Service Licen	\$66											ome, PA
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н			shock, or heart failure. List only Immediate Cause (Final	one cause on each line	9.				3,					Interv	val Between et and Death
	Physician /Medical		disease or condition resulting in death)	a 5+	rol	se.								160	lays
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o.	te be executed ysician and e burial-transit	Exa	resulting in death) Last	Due to (or as a	conseq	uence of):									
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Вох	ith ce itendi or use	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Feta	Ideath 3		pregnancy	,			2	3d. Date of Month	delivery Day	Year
0	e dea the at	sici	1 Yes 2 No	4☐ Pregnant at t 9☐ Unknown	time of d	eath 5[Other (specify)						,	
9.	The law requires thet the death certifica 11e hes been signed by the attending phoage 2 should be delached for use as th	Physician/Med	Part II. Other significant conditions of	ontributing to death bu	t not resi	ulting in the u	ınderlyina	cause divi	en in Part I		23e, Did 1	obacco us	se contribut	e to the cau:	se of death?
ds,	ires the signed d be del	1 by	, and an analysis of the second secon				,-3				10	Yes 2] No 3	Probably	4 Unknown
Ö	v require been si should b	etec									24a. Was	20	24b Mars	autoney fin	ndings available
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a			DE Wassesser sets and to modifical						00 Di	of Doort		202/No	101	res 2□N	10
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ð	Phy ar this aral d	!	27. Manner of Death	28a, Date of Injur	v	28b. Time o	_	28c. Injun Worl			28d. Describe			poony	
<u>o</u>	Attending r death. ector: After by the fune	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear)	Injury	М		Yes 2	No					
Division of	Atte ecto by th	IIIc	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At ho	ome, farm, st	reet, facto	ry, office			28f. Location (City or To			Rural Rout	te Number,
Ö	To the Hospital or Attending Physicien: within 24 hours effer death. To the Funerel Director: After this certificacompletely filled in by the funeral director,	Certification;			, _ ,,										
	Hospital 24 hours Funerei tely filled	cal	29a. Certifier 1 ✓ Certifying Ph (Check only 2 ☐ Medical Exam	ysician: To the best oniner: On the basis of	f my kno examina	wledge, deat	h occurre	d at the tin	ne, date an pinion, dea	id place, th occurr	and due to the ed at the time,	cause(s) date and	and manner place, and	as stated.	ause(s)
	the the the the the the the the the the	Medical	one)	and manner sta				9c. Licens						onth, Day, Y	
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9	Sta	ite	31. Date filed (Month, Day, Year)	32. Regista		iture				٥٠٠			,		
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State of Maryland	Department of Health and	d Mental Hygiene 🖰 🖰

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month NOV -2008 **Physician** 2:55 а м Hattie Marie Coleman /Medical 4a. Facifity Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manchester Carroll Longview Nursing Home 8. Date of Birth (Month, Day Year) Sept. 25, 1923 If Under 1 Year | If Under 24 Hrs. 9. Birthpface (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. Maryland Months Hours 1 □ M 2 X F 220-14-0551 83 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c City Town or Location 10d. fnside City Limits 10a State 10b County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Carroll Manchester Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 4704 Baughman Mill Rd. 21102 items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☑ Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Assembly Worker Black & Decker traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Heelth and Mental H tant: If Item 27 is marked other. Be William Rufus Driver Florence Edith Rimbey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4704 Baughman Mill Rd. Manchester, Md. 21102 Ronald Coleman - son or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If any injury or once. Manchester Baptist Ch. Cem. Nov. 18,2006 Manchester, Md. 4 ☐ Donation 5 ☐ Other (Specify) Eckhardt Funeral Chapel P.A. 3296 Charmil Dr., Manchester, Md. 21102 21. Signature of Euneral Service Licensee . Sath ELLI 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final **Physician** End disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NKIN Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner use as the burial-transit or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ö Month Year in the past 12 month 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be deteched t 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 1 Yes 2 N director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 trising Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this After thi 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner eath 28d. Describe how injury occurred 28b. Time of Medical Certification: 1 Unatural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 | Homicide hours after To the Hospital within 24 hours a To the Funerel Completely filled Hospitai 1 🔾 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature-and title-6 -0054218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Malcalmoline, neximina MD 21157 aman Kanewa 32. Adistrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Craddock Ruth Daisy 2006 ll a. ™ 11 09 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore 1919 E. 30th Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Year) 931 Days Hours 1 M 2 X 216-28-5687 75 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XXYes 2 □ No N/A Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 USA 1919 E. 30th Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black þ 3€Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rosewood State Hosp. Clinic Assoc. 2yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Staggs Ruth Holland Erushia McCanham ပ Ben 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3501 Milford Mill Road Baltimore, MD Gail Flowers-daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 11/18/2006 Arbutus 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST I adup 21202 1101 E. North Avenue Baltimore, MD 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tailure Heart 3 years ongestive **Physician** disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner ardtomyopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transi and attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) 4□Pregnant at time of death 2 No been signed by the should be detached Q | Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kidna 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a, Was an autopsy this certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and the of certifier

31. Date filed (Month, Day,

NOV

Year.

7

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

29c. License number

29d. Date signed (Month, Day, Year) 16/06

21202

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1000 E. Eager Sheet, Baltime

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Waginto z CV0/-/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 03 29 vrs. last birthday **Funeral** Days 1⊠M 2□F Hours Year Months Yrs Director NC 03 32 242-38-1641 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healith and Mental Hygiene. Important: If them 27 is anaked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Randallstown MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 U.S.A. 4 Oxyokė Ct Funera 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade <u>Construction Worker</u> Construction Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Coltrane <u> Alice_Patterson</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Peggy Campbell-Sister Oxyoke Ct., Randallstown, 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Calvary Mt. 11/21/06 Asheboro, NC 21. Signal of Funeral Service Licens 22. Name end Address of Facility
March F/H West 4300 21215 Wabash Ave, Baltimore, 23a. Part1. Elver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between immediate Cause (Final disease or condition resulting in death) Onset and Death Physician van exitates /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to infine diaticase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed signed by the attending physiclan and d be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnency 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division or Vital Records, 1 Yes 3 ☐ Probably 4 ☐ Unknown 2 No To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 12, 2006 Ralph Stephen Vincent Cully 4:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore. Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Aug. 2, 1 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 49 Yrs. Maryland 213-52-2456 Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notifled at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4245 E. Joppa Road 21236 U.S.A. Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or Items traumatic event, the Medical Examiner man 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) self-employed Elementary/Secondary (0-12) College (1-4or 5+) Owner wireless communication 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ralph Chester Cully Dorothu Gibson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun 4245 E. Joppa Rd., Baltimore, MD 21236 Mrs. Kellie Cully (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 11/20/2006 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** AS TOW - TOM A PLOGITIC 4000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tyes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an performed? 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Wo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 3 200C

State Registrar

6

DHMH 17 Rev 1/2001

Charles ST BUSIN NO ZIZE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Arran Chardes

	1 - For State Registrer	State of Maryl		artment of H			giene Reg. No.2	06 36446
Physician	1. Decedent's Name (First, Middle, La Verese Anita Cla	•				2. Date of De Month Novemb	er 15, 2	3. Time of Death 0239 M
/Medical Examiner	4a. Facility Name (If not institution, giv		tor	4b. City, Town, or Be1 A			4c. County	
Funeral	Upper Chesapeake 5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th	9. Birthplace (State or Foreign
Director	216-66-9359 Usual Residence of Decedent	□ M 2 □ F 52	Yrs.	Widnins Days	riours iviii.	Jan. 2	8, 1954	Maryland
the Maryland r28a-f ehow notified a	10a. State 10b. County	arford	. City, Town or Lo		bingdon			10d. Inside City Limits 1 ☐ Yes 2 To No
th with the 23s or 28 int we not	10e. Street and Number 2811 Meredith Co	urt		10f. Zip Code	21009		10g. Citizen of W	
ltema ltema	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Specify.	- American Indian, k, White, etc. white
— c ' iii -	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12 years	ducation ide completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of wor)	king	16b. Kind of Bu	
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more, M ages 1 and 2 and of Heelth t: If New 27 i	20a. Method of Disposition 1 Burial 2 Cremation 3 C	Removal from State		sition (Name of matory or other plac Crematory	e) 11/	Date 17/2006		City or Town, State
Baltimor Bernit. Pages Depertment of Important: If in eny Injury or of once.	21. Si nature of Fund Service	77	22	Name and Address Chimunek				
Pnysician //Medical	23a Pa/1. Enter the disease, or come shock, or heart failure. List only temperate the condition disease or condition resulting in death)	one cause on each line.	ophilic	er the mode of dyin	g, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
3760 care be executed at the burial-transit and the burial-transit and allea Examiner		b. Uue to (or as a cor c	nsequence of).					
P.O. Box 68 P.O. Box 68 at the death certifica by the attending philesched for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Dat Mor	e of delivery tth Day Year
ರ ಕೃಷ್ಣ ಕೃಷ್ಣ ಶ	Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did 1	tobacco use contr Yes 2 No	bute to the cause of death? 3 Probably 4 Unknown
I Rec The law The law page 2 st		hinitis				24a. Was auto perfe 1 Yes	psy prompd? p	Vere autopsy findings available rior to completion of cause of leath? ☐ Yes 200 No
Sion of anding Physiath. Srie Atter this he funeral disagrant.	1 ☐ Yes 2 ☐ No	28a. Date of Injury (Month, Day Yea	At home, farm, str	f 28c. Injur Worl M 1 [er: 4 Nursing H	28d. Describe	dence 6 Other	
To the Hospital or Att. within 24 hours after de completely filled in by the Medical Certific	29a. Certifier 1 Certifying P	nysicien: To the best of my miner: On the basis of exa						
To the Hospi within 24 hou To the Fune completely file	> Can Hy	and manner stated.	m.D		e number		29d. Date signed	ו (Month, Dey, Year)
State Registrar	30. Name and address of person who SEAN M. CU 31. Date filed (Month, Day, Year)	completed cause of death RTIN M, D 32. Registrar's S	,615	Print) W. MACPH	AIL LD,	STE 105	BEL,	AIR, MD 21014

			For State Registrar	State of Maryland	•	tificate of		wieritai i iy	Reg. No.	106	36447
¥	Physici /Medic	_	1. Decedent's Name (First, Middle, Las	zabeth Moleswo	rth Cr	compton		2. Date of Do Month Novemb	eath Day	Year	3. Time of Death 12:30 P ^M
7	Examin	. 5	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deat			nty of Death	
		2	13305 Yorktown Dr 5. Social Security Number 6. So		ot hirthday)	Bo If Under 1 Year	wie If Under 24 Hrs	8 Date of Bi	Prir	ce Geo	rge's ace (State or Foreign
***	Funeral Director			DM 2対F 86	Yrs.	Months Days	Hours Min.		1920	Count	/land
	yland now at		10a. State 10b. County	10c. City	Town or Lo	cation				10	d. Inside City Limits
	the Mar 28a-f sl	ector	Maryland Prince (George's	Bow	ie 10f. Zip Code			10g Citizen	of What Count	1 X Yes 2 No
	th with	al Dir	13305 Yorktown Dr	rive			7 15			l S tat e	•
36	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🔀 No		pecify Yes or Note Rican, etc.)	0- 14. F B Spe	lace - America lack, White, e	
21215-0036	72 hou "natura dical E	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deced	tent's Usual Occup kind of work done OO NOT use retired	eation during most of wo	rking	16b. Kind of	Business/Inde	ustry
2121	d within giene. or than the Me	Completed	Elementary/Secondary (0-12) 12	College (1-4or 5+)		Secreta				Law Fi	rm
Maryland	be do do	To Be C	17. Father's Name (First, Middle, Last) Parke W. Moleswo				18. Mother's Nar	ne (First, Middle an Knil		name)	
Mary	an is		19a. Informant's Name/Relationship (7			g Address (Street					'
			G. Michael Beach/ 20a. Method of Disposition 1X Burial 2 Cremation 3 C	20b. Pl	ace of Dispo emetery, crer	Yorktow sition (Name of natory or other place	Mov.			n - City or Tov	
Baltimore,	t. Pag rtment rtant; I		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen) Mt.	Olive	t Cemeter	v : 200	6	Freder	ick, M	aryland
Bal	permi Depa Impo any ir once.		21. Signature VI Furieral Service Licen	M001	98 75	bert A. 57 Wiscon	Pumphrey sin Ave.	Funera Bethes	l Home/ da, MD	Cha 20814 -	da-Chevy se. Inc. 3501
			23a. Part1. Ent the disease, or companions shock, or heart failure. List only	olications that caused the death one cause on each line.	. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Parkinson D Due to (or as a consequ		2					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	ence of):						
	xecuted and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ	ence of):						
68760,	tificate be executed g physician and as the burial-transit	edical E		.d							
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ord	w require been signature	ted l	Pulmonary Embo	lism							ably 4 □Unknown
Il Records,		Completed by	Hypertension_							b. Were autop prior to com death? 1 Yes	sy findings available apletion of cause of
Vital	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		• act pox Oth	or.	ath (Check only			
or	Phys this at dir	은	1 ☐ Yes 2 🔀 No 27. Manner of Death	I □ Impatient 2 □ E	R/Outpatier 28b. Time of	1 3 LI DOA	4 L Nursing F	lome 5 🔼 Res	how injury occ)
UQ	ng fter	tion	1 X Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	k? Yes 2∐No	2001 20001120	now injury boo		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide 1 Homicide		me, farm, str)	eet, factory, office		28f. Location City or To	(Street and Number, State)	mber or Rural	Route Number,
	e Hospital 124 hours a e Funeral I	Medical C	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowniner: On the basis of examination and manner stated.	vledge, deatl ion and/or in	occurred at the tie vestigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) and , date and plac	manner as sta e, and due to	ated. the cause(s)
	To the l within 2. To the l complet	Me	29b. Signature and title of certifier	0 //:		29c. Licens	e number		29d. Date sig	ned (Month, E	Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore Avenue, Laurel, Maryland 20707

State Registrar

			For State Registrar	State of Marylan	nd /, Depar	tment o	f Health and l		al Hygie	2000	36448
4	Physicia /Medic		1. Decedent's Name (First, Middle, Last Benjamin Du	Bose Sr.				M	te of Death onth		0300 AM
0	Examin		4a. Facility Name (If not institution, give				n, or Location of Deat	h		4c. County of De	eath A
	Funeral	**	GOOD SAMARITAN 5. Social Security Number 6. Se	HOSPITAL x 7. Age (In yrs.	last birthday)	If Under 1 Ye	ear If Under 24 Hrs	8. Da	te of Birth	9. 8	lirthplace (State or Foreign Country)
- 1	Director		77.70.9110	M 2□F	77 Yrs.	Months Da	ys Hours Min.	DI	te of Birth onth, Day, Ye	729	SC_
	and www.		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Loca	ation					10d. Inside City Limits
	Maryl e-f eho	tor	MD N/A		Balt	imor	e				1 X Yes 2 No
	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "naturel", or Itema 23a or 28e-1 show sumatic event, it a Medical Examinar must be notified at	by Funeral Director	10e. Street and Number 1744 E. 25 th S	street		10f. Zip Coo	1213		10g.	Citizen of What	Country?
	ter death	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. W	as Decedent Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Y to Rican	es or No-	14. Race - Ar Black, W	merican Indian, hite, etc.
36	rs after	y Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 反 No If Yes, Give Year or Dates:		☐ Yes 2 🗷				Specify:	Black
21215-0036	72 hours "naturel"	ted !	15. Decedent's Edi (Specify only highest grad	ucation	16a. Decede	ent's Usual Oc	ccupation one during most of wo	orking	16	b. Kind of Busine	ss/Industry
121	within 7 iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use re	etired)	,	12	bethleho	m Steel
d 2	be filed within 72 ho ital Hygiene. d other than "natui	Be Co	17. Father's Name (First, Middle, Last)	N/A	0,00	. • 10	18. Mother's Na		t, Middle, Ma		,,,,
/lan	2 should be and Mental is marked o	To B	David DuBose, S	Śr.			Marth	-			
Maryland	5 = 7 = 1		19a. Informant's Name/Relationship (7)	ype, Print) /Wife	19b. Mailing	Address (Sti	th Street	iural Rou BQ	te Number, C	re MD	21213
ore,	_ + = +		20a. Method of Disposition 1	Hemovai irom State	Place of Dispos cemetery, crem	ition (Name of atory or other	f place)	Date	20	c. Location - City	
Baltimore,	permit. Pages I Depertment of H Important: If ite any injury or ot once.		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen:) Po	ankwood	Name and A	ddras f Facility)4.(d de	Baltimo	remo
Ba	permit. Depert Import any inj		1Bn Clat	- MOBL	23 40	agen c	ddras t Facility Greene Fu rk Road B	nera paltiv	none N	ND 21212	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.	itti. Do not ente	i the mode of	dying, such as cardia	10 01 103	oratory arrest		Approximate Interval Between Onset and Death
0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. RECURREN		IRATOR	Y FAILUR	RE	153		1
>	Examiner		Seminatially list conditions	b. MUCUS	PLU 44	144					
A M	ed self	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse							
BENJAMIN 760. G	ate be executed nysician end he burial-transit		that initiated events resulting in death) Last	c. PNEUM (Due to (or as a conse							
	ate be hysicia the bu	lcal		d							
× 68	leath certificate attending phy I for use as the	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr						23d. Date of	delivery
DUBOSE P.O. Box	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	230. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown		Ectopic pregn Other (specif				Month	Day Year
3 9	s that t	by Ph	Part II. Other significant conditions of		sulting in the un	derlying caus	e given in Part I.	2			e to the cause of death?
ords	w requires that been signed the should be detailed.		Renal I	neuffluency					1 🗌 Yes		Probably 4 Minknown
ec	e law r has be	Completed							4a. Was an autopsy performe	prior death	autopsy findings available to completion of cause of 1?
<u></u>	ifficate or, pag	0	25. Was case referred to medical	-			26. Place of De		Yes 25	YNo 1LI	/es 2□No
<u> </u>	nysicia nis cert	To B	examiner? 1 Yes 2 No	Hospital: 1 Impatient 2	☐ ER/Outpatient	3□ DOA	Other: 4 Nursing			ce 6 Other (S	Specify)
0 0	ling Pr		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes 2 No	28d. I	Describe how	injury occurred	
Division of Vital Records.	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: Attenthis certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		home, farm, stre city)				ocation (Stre		r Rural Route Number.
(6)	dospitel 4 hours a Funerel C		(Check only 2 Medical Exam	ysician: To the best of my kr niner: On the basis of examin	nowledge, death	occurred at t	he time, date and place my opinion, death occ	ce, and c	ue to the cau the time, date	se(s) and manne e and place, and	r as stated. due to the cause(s)
	ithin 2 o the l	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. L	cense number		290	d. Date signed (M	onth, Day, Year)
	⊢ 3 ⊢ ŏ		tone	MD			RES DOO			10.30	. 2006
	6		30. Name and address of person who			Print) HOSP	DA:	**************************************	ORE	MD	
	en e	ate	KUMAR SUJEET, 31. Date filed (Month, Day, Year)	GOOD SAMAR 32. Registrar's Sign	nature		14L 13AL	1114	UKL	1 - 1/	
	Regist		NOV 1 7 20	-	M La	346					
	HMH 17 Rev 1/2	2001		1	S. Salar						

ORIGINAL

Bernard Rousevelt Dickers
06-08558 **UNK UNK**

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 36449

	F	- For State		1	Certifica	ate of	Death					eg No.	_ 0 0		0044.
Physicia Medical Exami	n/	1. Decedent's Name (First, Midd Bernard Roo		2. Date of Dea Month November					er 9, 2006 Year 1745 hrs						
		4a. Facility Name (if not institution 2808 Keith Street	on, give street and	d number)		41	City, To Temple		ocation of	Death			inty of Dea ce Georg		
Funeral Director		5. Social Security Number 246–90–4027	6. Sex		yrs. last birt	hday) Yrs.	If Under Months	1 Year Days	If Under Hours		8. Date of Bio 06/29/	,	Fore	irthplace ign ountry)	State or NC
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene fant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	I Director	10e. Street and Number 2808 Keith S 11. Marital Status 1 Never Married 2 N	12. Was	Decedent Ever d Forces? es 2 X		v Hig	hts 10f. Zip C	of Hispa Cuban, I	Mexican,	n? (Spec	cify Yes or No		Race - Ame White, etc.	1 X untry?	side City Limits Yes 2 No an, Black,
21215-0036 uld be filed within 72 hours afth Mental Hygiene marked other than "natural" c event, the Medical Examine	\circ	15. Decedent's Education (Spe Elementary/Secondary (0-12) 11 17. Father's Name (First, Middle	Collect			Decedent' during mo	s Usual O	ccupationg life. E	on (Give ki DO NOT u	s Name (F	d) First, Middle,	16b. Kind o	of Business	s/Industry	
D 2121 should be find Mental r is marked	To Be	Roosvelt Dick 19a. Informant's Name/Relation Cynthia L. Dic	ship (Type, Print)		-	_		(Street		per or Ru	e Swa ral Route Nui CKY MO				de)
Baltimore, MD 21215-00; pemit. Pages I and 2 should be filed within Department of Health and Mental Bygiene Important: If item 27 is marked other tillingry or other traumatic event, the Mec.		20a. Method of Disposition	n 3 X Remov	ral from State	20b. Place of	of Disposit ory or othe Ceme	ion (Name er place)	of ceme	etery,	- 1	Date 9/2006	20c. Locar	tion - City o	or Town, S	
Physician Department of the position of the position of the physician of t	ł	23a Part I. Enter the disease, o	25	nat caused the	death. Do no	Cha 1150	rles 1 Fa:	L. st F	Stev ort	Aven	Funera ue, Ba espiratory an	1timor	reM	D 212	oximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final diseas or condition resulting in death)	e on each line. e a. <mark>Gunsh</mark> o	t wound to	head									Betw	veen Onset and Death
, W.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	Due to (or	as a conseque											
8760, ifficate be executed ng physician and taskings the burial - transit	edical	UNPENDED IF FEMALE:	d AMEND	ED yes, outcome o	f pregnancy							23d. Da	ate of delive	ery	
Box 68760, e death certificate bo the attending physic ed for use as the bur	Physician//	23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	the 1 L 4 P nknown 9 L	ive birth regnant at time Inknown	of death	5 Oth	al death ner (S <i>peci</i>			pregnand		Mor		Day	Year
Division of Vital Records, P.O. Box 68: rate or Attending Physician: The law requires that the death certificate and the death certificate has been signed by the attending lied in by the funeral director, page 2 should be detached for use as ited.	Completed by Pl	Part II. Other significant cond	itions contribut	ing to death bu	t not resultin	g in the u	nderlying	cause giv	ven in Par	rt I.	1 Ye	an 2	3 Pr	autopsy fin	se of death? Unknown Indings available on of cause of
al Reco an: The laverificate ha	Φ	25. Was case referred to medic					2		of Death (Check or	1 Yes	ormed? 2 No	1 🗸		2 No
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director.	tion: To B		luing No.	Inpatient Date of Injury Month, Day, Year) ND:	28b.	Time of Ir JND: 7 hrs		Bc. Injury	Other ₄ y at Work es 2	? 2	Home 5 8d. Describe subject sho			ner: Scene	
Division of Norther Hospital or Attending Phwithin 24 hours after death To the Funeral Director: After to completely filled in by the funeral	Certification:	3 Suicide 6 Co	uld not be ermined (Spe	Place of Injury	- At home, f Family	arm, stree				2	or Town, 808 Keith S	State) treet, Temp	ole Hills, N	Md.	te Number, City
To the Ho within 24 l To the Fu completely	Medical	(Check only one) 2 Medical Ex 29b. Signature and title of certifications		e best of my kn asis of examina ner stated.	owledge, de ation and/or	ath occur investigati	ion, in my	opinion,	death occ	ce, and d	the time, date	and place, a	anner as st and due to signed (A	the cause	
* 3		30 Name and address of person	•	cause of death	n (Item 23a)			O.C.N	Л.E.			Novem	ber 10, :	2006	
	tate		sistant Medi		er 111	Penn S	treet, B	altimo	re, MD	21201					
Regis	frar	INU Y L	2000	Frank St. See Lake	100	1. W 2 3 ONL	Market								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Age (In yrs. last birthday) **Funeral** Days 10M 20F Director Usual Residence of Decedent 10d Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If then 27 is marked than "inatural", or items 23a or 28a-f show any injury or rother traumatic event, the Medi-al Ex milner must be notified at any injury or other traumatic event, the Medi-al Ex milner must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country Jovember 14, 2006 at 9:47Am Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, 1 Never Married Married 2 should be filed within 72 hours after and Mental Hygiene. 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Elementary/%9condary (0-12) De 1-40r 5/1 Be lethod of Disposition Burial 2 Cremation 3 Removal from State 5 Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BrensT Physician ASTA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 1 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed2 yes 2 No Division or Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 Øother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No after death Director: 2 Accident completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Bolto. M. J 2120x 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygien 2 005

For State Amend item#19b, perFH, G861, 11/22/06 Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 3:00 A M NOVEMBER 15, 2006 JOSEPH PATRICK DONAHUE, SR. /Medica! 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner ST. CATHERINES NURSING CENTER CARROLL **EMMITSBURG** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. Director 023.01.0907 91 JAN 30, 1915 MA Usual Residence of Deceden with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show 1 ☐ Yes 2 ☐ No XX MD CARROLL **EMMLTSBURG** Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 331 SOUTH SETON AVE 21727 USA deeth 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2KX No Specify: þ 3 Widowed 4 Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiane. **AGENT** INSURANCE 12 3 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Peges 1 and 2 should be fit Depertment of Health and Mental I-Important: If item 27 is marked of any injury or other traumatic even pope. and Mental ဥ ANNA SULLIVAN PATRICK DONAHUE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Manchester 19a. Informant's Name/Relationship (Type, Print) PO BOX 849 TIAMPSTEAD, MD 21102 JOSEPH P. DONAHUE, JR. SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XIX Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) **CLEN HAVEN CEMETERY** 11.17.2006 GLEN BURNIE, ND 21. Signature of Foneral Service License 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. ueco) 426 CRAIN HWY SW GLEN BURNIE, MD 21061 K GREGORY FINK M01148 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed and Due to (or as a consequence of): physician a s the burial-.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year ģ Month 4 Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other ۵ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DDA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No deeth. Director: / 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Medicai 29a. Certifier Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 32. Registrar's Signature 31. Date filed (Month, Day, Year) reste! State 2006 NOV 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydien 2006

			State of Marylar	nd / Depa		ealth and	Mental Hyg		36452	
Physici /Medic		1. Decedent's Name (First, Middle, Last) WILLIAM	Dowdell				2. Date of Death Month NOVE mi	Day 1/ 20	06 1.101 M	
Examin Funeral		5. Social Security Number 6. Sey	treet and number) / Health & Rehab (7. Age (In yrs.	last birthday)	4b. City, Town, or If Under 1 Year Months Days		licott City S. Date of Birth	4c. County of D	Howard Birthplace (State or Foreign Country)	
Director		239-50-6903 Usual Residence of Decedent 10a. State 10b. County		70 Yrs. ity, Town or Lo			October 1	, 1936	Alabama 10d. Inside City Limits	
vith the Mar or 28a-f sl	Director	Maryland How 10e. Street and Number	/ard		10f. Zip Code	licott City	10	1 Tyes 2 No		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23e or 28e-f show spirity or other treumstic event, Its Medical Examinar must be notified at once.	by Funeral Director	8439 D Falls Run Rd. 11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced			Was Decedent of Hi f Yes, specify Cuba 1 Yes 2 No	21043 ispanic Origin? in, Mexican, Pue Specify:	(Specify Yes or No- orto Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White		
within 72 hou iene.	Completed I	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	during most of w	rorking	16b. Kind of Business/Industry Engineering		
should be filed and Mental Hygis marked other amatic event,	To Be Co	17. Father's Name (First, Middle, Last) William Oliv	ver Dowdell				ame (First, Middle, A	^{Aaiden Sumame)} Emma Hend	rick	
t and 2 sho fealth and sm 27 is mu ther treum		19a. Informant's Name/Relationship (Typ. Mrs. Elenore L. Dowdell 20a. Method of Disposition	Wife	8			icott City, Man			
permit. Pages Department of I Importent: If it eny injury or o		1 Burial 2 Cremation 3 Re '4 Donation 5 Other (Specify)	emoval from State	Crest Law	natory or other place	Sardens	11/16/2006	Marriott	sville, Maryland	
Physician /Medical Examiner e perior and principle of pr	dical Examiner	23a. Part1. Enter the disease or complications, or heart failure. Est only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of): WM a quence of): WON a	3877 Cer the mode of dyin PNUM Y Em P Cry Grif	Moderate Description	ia Pike Ellicott ac or respiratory arre	City, MD 210	Approximate Interval Between Onset and Death	
w requires that the death certificate be executed been signed by the attending physicien and should be delached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year	
law requires that as been signed be detailed.	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause give	en in Part I.			te to the cause of death?	
VICAL DECOME sicien: The law r certificate has be lirector, page 2 sh	e Completed	25. Was case referred to medical				26 Place of D		y prior deat		
ding Phy	ertification: To Bo	examiner?	ospital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At I building, etc. (Spec	-	eath (Check only one) Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospitel or Attent within 24 hours after deal To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier Check only one) Certifying Phys	ician: To the best of my kner: On the basis of examinand manner stated.	nowledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the ca curred at the time, da	ause(s) and manne ate and place, and	er as stated. due to the cause(s)	
To th within To th	Me	29b. Signature and title of certifier	au	am (22a) /T	29c. Licens	306 4	2	9d. Date signed (M	North, Day, Year) Let 13 200 6 I Ballme MI	
Sta	ate	31. Date filed (Month, Day, Year)	Pa (hi 32. Registrar's Sign	26/-	107 B	ack 1	levy No	ckRoad	1 pe//ma mo	
Regist	I_{-k}	NOV 1 7 200	06 Magnes	M. A.	and it				1	

State of Maryland / Department of Health and Mental Hygiene 0 6 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** DiStefano 0007 November 12 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 7. Age (In yrs. last birthday) If Under 1 Year Months Days 9. Birthplace (State or Foreign Country) Louisiana If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)
July 21, 1920 5. Social Security Number 6. Sex **Funeral** Hours 1 □ M 2 □ F 86 219-26-3244 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State or then "netural", or items 23a or 28a-f shov The Medical Exa⊓inar must be notified at 1 ☐ Yes 2√ No Fallston Harford Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21047 2117 Laurel Brook Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: white Completed by 3 □ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other then clothing seamstress 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be filt Depertment of Health and Mental Hy Important: if Item 27 Is marked oth any liquy or other treumattic even 2008: Be Dora Brocato Phillip Brocato 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2123 Bellvale Road, Fallston, MD 21047 19a. Informant's Name/Relationship (Type, Print) Stephanie Erdman/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Comation 3 ☐ Removal from State Most Holy Redeemer Cem. 11/15/06 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Figurature of Funeral Service Lizensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. Servain 610 W. MacPhail Road, Bel Air, Md. 21014 Rant. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fibrillation Ventricular 20 hours Physician disease or condition resulting in death) /Medical Examiner Sinus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 s 1□ Yes 2 46 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 \(\triangle \text{Nursing Home} \) 5 \(\triangle \text{Residence} \) 6 \(\triangle \text{Other} \((Specify) \) 1 Tes 2 No Certification: To After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Mannes-of Death 5 Pending 1 Naturai To the mours effer death.

To the Funerel Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier November 12, 2006 D35012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Ave Bel Air Md. 20014 LYNICH J. Kevin mp 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2006 State Registrar

06-08520 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Roland Drakeford 36454 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day November 8, 2006 2123 hrs Medical Examiner 4b. City, Town, or Location of Death 4a Facility Name (if not institution, give street and number) 4c. County of Death Good Samaritan Hospital Baltimore NA If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or 7. Age (In yrs, last birthday) 5 Social Security Number **Funeral** Foreign New Jerse Months Days Hours Director 26 M 2 F 151-88-4752 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore 1 Yes 2 No NIA 28a-f show mD after death with the Maryland Director 10f Zip Code 10g. Citizen of What Country 23a or 28a-f 10e. Street and Number 1216 Evesham 21239 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S or items 2 must be r If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. Never Married 2 Married No Specify: Black If Yes, Give Year Yes 2 No specify Widowed Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) ages 1 and 2 should be filed within 72 b nt of Health and Mental Hygiene 1: If item 27 is marked other than "n other traumatic event, the Medical E. Elementary/Secondary (0-12) Baltimore, MD 21215-0036 ochool Oth tudent 18 Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Drakeford Hithea Be Koland ra 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (9a. Informant's Name/Relationship (Type, Print) C'ase wor 3007 E. Biddle St. Baltimore, MD 21213 livan ebumn 20c. Location - City or Town, State Date 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) t: If i 27 Cremation 3 Removal from State Burial Lansdowne MD Important: injury or off Cemeter -16-00 Donation 5 Other Specify 270 Fredhilton Fass 22. Name and Address of Facility 21. Signature of Funera P. March Funeral Home Baltimore, MD 21229 Approximate Interval Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and fure/List only one cause on each line /Medical Death Asthma e Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED X AMENDED 19b, 23a, 27, perFH, ME, G862, 12/11/06 TT Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy ph) 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? certificate has performed? 2 No Yes 2 No 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other₄ Hospital: 1 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending Director: the 2 Accident Investigation in by 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be Suicide or Town, State) determined Homicide 29a Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within . Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d Date signed (Month, Day, Year) 29c License number November 9, 2006 O.C.M.E. ell 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

		•	For State Ragistrar	State of Maryland /	-	artment of H		Mental	Hygien Reg. N	ZUUb	36455	
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Joy S. Ervi					2. Date of Month 11/		006 Year	3. Time of Death 12:00 pm	
1	Examin	100	4a. Facility Name (If not institution, give 2055 Liza Way			4b. City, Town, o Gambri		ath		c. County of Dea	th	
	Funeral Director		5. Social Security Number 6. Se 219-38-7017	x 7. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days		in. (Monti	of Birth h, Day, Yea 6/19	r) C	thplace (State or Foreign buntry) MD	
	aryland show		Usual Residence of Decedent 10a. State 10b. County MD Anne	e Arundel		cation ambrills		· ·	•		10d. Inside City Limits 1 □ Yes 2 No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hyglene. Important: if item 27 is marked other then "natural", or iteme 23s or 28s-f show says injury or other traumatic event, the Modical Extractional be multipled at ADEs.	Director	10e. Street and Number			10f. Zip Code		1054	1	Citizen of What Co	ountry?	
	death w	Funeral	2055 Liza Way	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H	ispanic Origin?	1054 (Specify Yes of erro Rican, etc.	or No-	14. Race - Ami Black, Whi		
036	ours after rai', or ite	<u>م</u>	1 Never Married 2 Married 3 Widowed 4 Nover Nover New York	1 ☐ Yes 2 ○No If Yes, Give Year or Dates:		l □ Yes ¾Ø No	Specify:			Specify:	white	
Maryland 21215-0036	thin 72 ho e. en "natu Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)		(Give	lent's Usual Occup kind of work done OO NOT use retired	during most of v ()	working	16b.	Kind of Business	•	
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ırylar	should by nd Menta marked matic e	To	Joseph King 19a. Informant's Name/Relationship (7)	ype, Print) 19	b. Mailin	g Address (Street	and Number or	Rural Route N	ce Bo	or Town, State,	Zip Code)	
e, Ma	1 and 2 s Heelth ar em 27 ie ther trau		Sharon Lynn S	Sherman /Daugh	nter	2055 I sition (Name of	iza Wa	ay Gam	bril.	Ls MD 2	21054	
Baltimore,	Pages ment of h lant: if its		1 ☐ Burial 2 ☒ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Bavv	iery, cren IEW	Cremat	-		006	Baltimo	ore, MD	
Ball	Depenti Depenti Import eny in		21. Signature of Euneral Service Licens	Victor Doda	Ch 15	Name and Addre larles I 01 E/.	ss of Facility Stev Fort <i>P</i>	vens F Avenue	unera , Ba	al Home Itimore	'MD 21230	
	Physician		23a. Part1. Enter the disease, or compi shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line.	mot ente		g, such as card	liac or respirate	ory arrest,		Approximate Interval Between Onset and Death	
jt.	/Medical Examiner		resulting in death)		Due to (or as a consequence of):							
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8760,	cate be executed only siclen and the burial-transit	ai Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):								
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P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and age 2 should be detached for use as the burial-transfer	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			_	23d. Date of de Month	livery Day Year	
	w requires thet is been signed by should be detail	ρ	Part II. Dther significant conditions co	ntributing to death but not resulting	in the ur	nderlying cause giv	en in Part I.		Did tobacco	_	the cause of death?	
Division of Vital Records,	he law req e has beer age 2 shou	Completed			•			- 1	Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of	
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u of	ding Phys. After this of funeral dir	on: To	1 ☐ Yes 2 ☑ No	1 Inpatient 2 EH/C	Outpatien Time of Injury	28c. Injur Wor	/ at k?			6 ☐ Other (Spe ury occurred	ocify)	
ivisio	deatl deatl ctor: y the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Ptace of Injury - At home, building, etc. (Specify)	farm, stre		Yes 2□No		ion (Street a		ural Route Number,	
	ospitei or A hours after uneral Dire ly filled in b		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam)	sician: To the best of my knowledge	ge, death	occurred at the tin	ne, date and pla	ace, and due to	the cause(s) and manner a	s stated.	
	To the Hospitei within 24 hours a To the Funeral Completely filled	Medical	one)	inar: On the basis of examination a and manner stated.		29c Licens	a number		29d D	ate signed /Mon	h, Day, Year)	
)	1) = s = o		30. Name and address of person who co	(Bah, typ		Do	10052		,	11/15/0	6	
			30. Name and address of person who co	ompleted cause of death (Item 23a	an Ca	Porkwi	ry ar	nuapoli	ء ارا	>		
	Sta Registi		31. Date filed (Month, Day, Year) NOV 1, 7, 20	32. Registrar's Signature		Sale of the sale						

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ELLIS Month Year DAVID **Physician** 4:30 PM NOVEMBER 14,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospital Center 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 A 5. Social Security Number 6. Sex **Funeral** 1 ☑ M 2 □ F Min Months Days Hours Yrs. 60 Director 213-44-8608 Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artener of Heath and Mental Hyglene.
ortent: if item 27 is marked other than "natural; or iteme 23a or 28a-f show inlury or other transmissible in items and inlury or other transmissible inclined as 1 ☐ Yes 2 No Finksburg MD Carroll Be Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21048 USA 2525 Baltimore Boulevard #32 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lillian Margaret Hughes James Byron Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Baltimore Blvd #32 Finksburg, MD 21048 Mrs. Linda Marie Ellis (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o importent: if any injury or once. 11/18/2006 Lake View Mem. Park Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) HATCHT AFONERALLY HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) inoma **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner physicien and the burial-transif To the Hospitel or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of): P.O. Box 68760, for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the 6 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 No 2 No 1 TYes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manne of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural thours after death.

Funeral Director: Aftely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified Helen, M.D. CARROLL HOSPITAL CENTER, MY 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HELOW, M.D. 32. Rayistrar's Signature. Registrar

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l r		181-42-1447	15 M 2□F	55 last birth	rs. Months Day			1'95'1 P). Birthplace (State or Foreig A ^{Country)}		
	1	Usual Residence of Decedent									
		10a. State 10b. County		10c. City, Town					10d. Inside City Limit		
1	tor	MD Baltim	ore	Randal	Istown				1 Tyes 32N		
	I Director	10e. Street and Number 9855 Branchleigh	Road		10f. Zip Cod 21133			10g. Citizen of Wh USA	at Country?		
	by Funeral	11. Marital Status 1 □ Vever Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1	? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - American Indian, Black, White, etc. Specify: Black		
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	Be	17. Father's Name (First, Middle, La Charles Fauset				18. Mother's N	lame (First, Middle, Roberts	Maiden Surname)			
	ပ္	19a. Informant's Name/Relationship Patricia Plato/Si	(Type, Print)	19b. 98	Mailing Address (Stre 55 Branch	eet and Number or leigh Roa	Rural Route Numbered Randall	er, City or Town, St	ate, Zip Code) D 21133		
		20a. Method of Disposition 1 ☐ Burial 2DC remation 3		20b. Place of cemetery	Disposition (Name of crematory or other peake Crem	place) atory Inc	₩8v 9 :. 2006	20c. Location - Co	ty or Town, State		
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	6	Part II. Other significant conditions					24a. Was autop	an 24b. We price med?	ere autopsy findings availab		
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	/Medic	al		Tour or Lanction of Dogth		,,	
	Examin	er					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	1 Year If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparmirent of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Insurat: if itam 27 is marked other than "natural, or Itams 28a or 28a-1 show any injury or other traumatic avant, Ita Medical Examiner must be rollified at once.		21 Signature of Lyaral Service Licensee.	d Address of Facility	apel rvices	8800 Har Parkvil	ford Rd.
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3760,	ate be nysicia he bu		d				
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	Attar ar dea actor by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide	, office	28f. Location (Stree City or Town, S	et and Number or Ri	ural Route Number,
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	To tha Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the t	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)
	To t withi To tl	Σ	29b. Signature and title of certifier 29c	. License number	29d	. Date signed (Mont	
•			Wind Kling mo	D31295		11/16/1	6
	6		30. Name and address person who expleted cause of death (Item 23a) (Type, Print) (701 N Charles Strut Suita 4202 78 WS	va md 2	1204	2004 20 Table 1 1955 Action 2	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2 Date of Death 3. Time of Death **Physician** /Medical 4b. City. Town, or Location of Death

Baltimo 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner laney TIMOR 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Min Director nce of Decedent 10d. Inside City Limits 10b. County 10a, State 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at atonsville 1 ☐ Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 No f Yes, Give fear or Dates: 1 Never Married 2 Married Maryland 21215-0036 ٥, 1 ☐ Yes 2 🖾 No Specify: δ 3 Widowed 4 □ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry endary (0-12) Stodian other than College (1-4or 5+) or other traumatic event, Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liqury or other traumatic event pope. Be 19b. Mailing Address Street and Number or Rural Route Number, Car or Town, State, Zip Code) toste Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Method of Disposition
Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** BLADDER CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical after death.

I Director: After this certificate has been signed by the attenums ray, and in by the funeral director, page 2 should be detached for use as the total in by the funeral director, page 2. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 🗌 Yes 2 No 2X No 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated

DR. TARIO MAHMOOD 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifie

2300 DULANEY VALLEY RD. 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar 2006 29c. License number

TIMONIUM, MD 21093

29d, Date signed (Month, Dav. Year)

DHMH 17 Rev 1/2001

NOVEMBER 14,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOV. 14 Day 2006 Year 10:15% Charles J. Fisher /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care - Rossville Rossville Il Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Dec. 25, 1919

8. Birthplace (State or Country)
Maryland 9. Birthplace (State or Foreign **Funeral** 1**∑** M 2 ☐ F 216-10-835B 86 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow Baltimore Middle River MD 1 TYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7222 A Oliver Beach Road 21220 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Work shipyard Beth Steel 8th other permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Important: if Item 27 is marked other any Injury or other treumatic event Spice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MArgaret Davis Charles J. Fisher Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7222 A Oliver Beach Road Balto. MD 21220 Elizabeth Pickle 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Tremation 3 ☐ Removal from State Bayview Crematory 11/15/06 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Elus 23a. Part1. Enter the disease, or complications that caused he death. Shock, or heart failure. List only one cause on each line. Connelly Funeral Home of Essex Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à of Vital Records, 1 Yes 2 No 3 Probably Unknown Be Completed Havanced 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Division or Attending s efter dec. Natural 5 Pending Injury 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital of within 24 hours of To the Funerel D Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b, Signature and title ol certifier 56 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \$1061, akwood Rd 7845 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 11 **Physician** 10 THEODORE 2006 4:40p M **FAJKOWSKT** JOSEPH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 8358 OLD PHILADELPHIA RD. ROSEDALE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 POLAND 8. Date of Birth (Month, Day, Year) 02-06-1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1₩ M 2□ F 216 12 3987 Director 83 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State rel', or Items 23e or 28a-f show Examiner must be notified at BALTIMORE ROSEDALE MD 1 ☐ Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8358 OLD PHILADELPHIA RD. 21237 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) FOOD PACKAGING INSPECTOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hisant: If item 27 is marked other. Be JOSEPH **FAJKOWSKI** STEPHANIE **JASINWSKI** ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or othar treu QDG. DOROTHY R. JEAN FAJKOWSKI/WIFE 8358 OLD PHILADELPHIA RD., ROSEDALE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 11-16-2006 BALTIMORE, MD STANISLAUS 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE., ROSEDALE, MD 21237 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a such line. Immediate Cause (Final Physician rostate disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner S- uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760 physician Physician/Medical the as attending 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death al or Attending F after death. After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier D-51555 Franklin Sq. Dr. St. 2200 Balto, MD. 21237 person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature State Registrar

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			for State Registrar		State of Ma	aryland /		nent of F		Mental H	ygiene Reg. No		36462	
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	Funcial		5. Social Security N	lumber 6. Sex	Hospital	e (In yrs. last	hirthday) If L	Inder 1 Year	If Under 24 Hrs	8. Date of B	idh	NA	(C)	
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	Physician /Medical Examiner	ier	Immediate Cause (disease or condition resulting in death)	n Ca.	e cause on each lin	e. Zwywo a consequenc G	ma e of): Collap	mode of dying	g, such as cardiad	c or respiratory i	arrest,		Approximate Interval Between Onset and Death	
68760,<	or Attending Physician: The law requires that the death certificate be executed titer death. Director: Atter this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the bunat-transit.	ledicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.											
P.O. Box	at the death cer by the attendin tached for use	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ₱ 9 ☐ Unknown	months?	tc. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 🗌 Fetal deal		ic pregnancy (specify)				23d. Date of delivery Month Day Year		
ς, Π	res that igned to be det	by P		icant conditions cont			in the underly	ng cause give	n in Part I.	23e. Did	tobacco u	use contribute	to the cause of death?	
ord	w require been sign		Corc	lis vascul	r dice	ese.				1 🗆	Yes 2	□ No 3 □ 1	Probably 4 Unknown	
ecc	elawr hasbe je 2 sh	Completed	Hyp	ertension						24a. Was	psy	24b. Were a	autopsy findings available completion of cause of	
ā	n: The l licate ha									1 Nes	ormed? 2 No	death?	s 2 🗆 No	
2	scerti	To Be	25. Was case referrexaminer? 1 Yes 2 1	ш	ospital:	2 G EB/C	outpatient 3	Othe	26. Place of Dea					
) of	nding Physician: Ti th. : After this certificate ! tuneral director, pa		27. Manner of Death	1	28a. Date of Injury (Month, Day		Time of	28c. Injury	r: 4 Nursing H	28d. Describe	how injur	occurred	ecify)	
sior	endin sath. or: Af he fur	atio	1 XNatural 2 Accident	5 Pending investigation	(World), Day	rear)	Injury M	Work	es 2 □ No					
Division of Vital Records,	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injurbuilding, etc.	. (Specify)				City or To	wn, State,)	Rural Route Number,	
	ne Hospital n 24 hours a ne Funeral to bletely filled	Medicai	29a. Certifier (Check only one)	1⊠ Certifying Physi 2☐ Medical Examin	cian: To the best of er: On the basis of and manner stat	examination a	ge, death occur nd/or investiga	red at the time tion, in my op	e, date and place, inion, death occur	, and due to the rred at the time,	cause(s) date and	and manner a place, and du	as stated. se to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and	title of certifier				29c. License	number		29d. Dat	e signed (Mor	nth. Day, Year)	
	^		1	0	. M.S			PI	9584		1 1	/14/2	006	
	10		4	ess of person who con	npleted cause of de	ath (Item 23a)	(Type, Print)							
its.	Sta	10 ³	Li Zhan 31. Date filed (Monti	-	32 Repleter	Jane.	ritan H	ip. tel	, 5601	Lock Re	ven 1	Blud,	Baltons, M.D.	
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Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician NOV 6006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard County General Hospital Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Yrs. Director 216-26-7817 Usual Residence of Decedent February 23, 1923 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Maryland Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 U.S.A 3574 Mt. Ida Dr. Apt B 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Domestic Work other than Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Pages 1 and 2 should be filed w then of Heelth and Mental Hygien tant: if Itam 27 is marked other ti jury or other traumatic event, ID. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Young Margaret Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth ar important: if itam 27 is any injury or other trau 3574 Mt. Ida Dr. Apt B Ellicott City, Maryland 21043 Mr. Jospeh M. Fuller Husband 20a. Method of Disposition

12 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State important: if any injury o once. 4 □Donation 5 □ Other (Specify) 11/16/2006 Marriottsville, Maryland Crest Lawn Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A.

3871 Old Columbia Pike Ellicott City, MD 21043
shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SHOCK **Physician** /Medical Que to (or as a consequence of) Examiner 14 cmust Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ROLOMY OF ATH or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) physicien a s the burial-P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1) Least Munonavi 3 Probably 4 JUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? certificete 1☐ Yes 2 HO Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ 1√0 1 Impatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A
completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the fine idste and place, and due to the cause(s) and miscourse as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14240126 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

7 2006

			1 - For State Registrar	State o	f Maryla		artment of H			giene Reg. No.	4000	36464		
45			Decedent's Name (First, Middle, Las	t)					2. Date of De	ath		3. Time of Death		
	Physici /Medio			Gail I	B. Ferg	uson			Novembe	Day er 9	2006	12:28 P M		
8	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of De			County of Death			
			Shady Grove Adver	tist H	ospi tal		Roc	kville			Montgon	nerv		
	Funeral		5. Social Security Number 6. Se	3X		s. last birthday)	If Under 1 Year Months Days	If Under 24 H		th Vear	9. Birth	place (State or Foreign		
	Director		1/1-34-1/52	_M 2[X]F	64	Yrs.	World's Day's	TIOUIS IN	Nov. 4			sylvania		
	pur *		Usuel Residence of Decedent 10a, State 10b, County		10c C	City, Town or Lo	cation			,	7	10d. Inside City Limits		
	lanyla eho	ō			1007	,						1√2 Yes 2 □ No		
	28a-1	Director	Maryland Montgome	ery			Rockvill	<u>-е</u>		10a Citi	izen of What Cou	**		
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8	el', o	by	3 XWidowed 4 □ Divorced	If Yes, Giv Year or D			I∐Yes 21⁄2 No	Specify:			Specify: W	nite		
ည်	tiled within 72 hours after deeth with the Maryland Hygiene. sther then "naturel; or items 23a or 28e-f ehow ent, tre Medical Examiner must be notified at	Completed by	15. Decedent's Ed (Specify only highest grad			16a. Deced	lent's Usual Occupa	ation	vodkina	16b. Ki	nd of Business/Ir			
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Maryland 21215-0036		1	19a. Informant's Name/Relationship (7 Abigail Pensky/Da				g Address (Street a Kensingto							
ტ _	1 and 2 Health tem 27 i		20a. Method of Disposition	dgiitei	20b.	Place of Dispo	sition (Name of				cation - City or T			
و	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐		State	cemetery, cren	natory or other place		. 14,		200			
altimore,	permit. Page Depertment Important: if eny injury or once.	1	4 □Donation 5 □Other (Specify 21. Signature of Funeral Service Licens		l'u			20	06	De C	lesda, M	aryland		
Ba	permit. Pages 1 Depertment of H Important: if ite ony injury or ot once.	1			MOO1	- Ro	bert A. l	Pumphre	y Funeral	L Hon	ne/Rockv	ille, Inc.		
			23a. Part1. Enter the disease, or comp	lications that c	aused the dea	ath. Do not ente	OWEST MOT or the mode of dvino	ntgomer 1. such as cardi	y Ave., Ro	ockvi	ille, MD	20850-2805 Approximate		
п			tmmediate Cause (Final											
*	Physician /Medical		disease or condition resulting in death)	u								2 weeks		
	Examiner				Montgomery Cranatorium 2006 Bethesda, M. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rocky 300 West Montgomery Ave., Rockville, MD. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Peritonitis The to (or as a consequence of):	0								
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	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
o,	exec en an rial-tr	Exa	resulting in death) Last	Due to ((or as a conse	quence of);								
8/60	cate be executed physicien and the burial-transit	dicai		d.										
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XOR	death certifi e attending I id for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1 ☐ Live b	come of pregninth 2 Fet		Ectopic pregnancy			2	23d. Date of deliv	*		
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	sician: The certificate he rector, page								1 ☐ Yes	2 [€] No	1 Yes	2 No		
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	_	eath Check only o					
ō	Physical dis	<u>유</u>	1 Yes 2 No 27. Manner of Death	28a. Date (ER/Outpatien 28b. Time of	3 DOA	4 🗆 Nursing	Home 5 Resid			(y)		
0	th. : After s funer	tlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Mont	th, Day Year)	Injury	28c. Injury Work M 1 \(\) Y	? 'es 2 ☐ No			, 000200			
DIVISION	af or Attending after death, I Director: Atter d in by the fune	itica	3 ☐ Suicide 6 ☐ Could not be	28e. Place	of Injury - At I	nome, farm, stre	eet, factory, office		28f. Location (S	Street and	d Number or Rura	al Route Number,		
ב ב	Dir	Certification:	4 Homicide determined	buildii	ng, etc. (Spec	uty)			City or Tox	vn, State))			
	Hospital or 24 hours after Funerel Direction in 184 hours after 184 hours		29a. Certifier 1 X Certifying Phy (Check only 2 Medical Exam	sician: To the	best of my kn	owledge, death	occurred at the time	e, date and place	ce, and due to the	cause(s)	and manner as s	stated.		
	the Hos in 24 hc he Fun pletely	Medical	(Check only 2 Medicat Exam	and man	asis of examin	ation and/or inv	estigation, in my op	inion, death oc	curred at the time,	date and	place, and due to	o the cause(s)		
	To the within 2. To the complete	Σ	29b. Signature and title of certifier				29c. License	number		29d. Date	e signed (Month,	Day, Year)		
	×		NUVU AT	17 P.1.	CURU	JILL A.	WD D46	187		Nove	ember 10	, 2006		
	30		30. Name and address of person who c											
	J		Ajit P. Kuruvilla				ille Pike	#208,	Rockvill	e, M	aryland	20852		
	Sta Registr	1.4	31. Date filed (Month, Day, Year) NOV 1 7 20	- 20	gistrar's Sign		e and a							
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ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 6 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician Dorothy Fletcher** ovember, 13,2006 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death? 4c. County of Death Examiner altimore If Under 1 Year | If Under 24 Hrs. | 8, Number 6 Sax 7. Age (In vrs. last birthday) Security Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Days Hours Min 1 M 2 TF 214-64-5044 54 May 11, 1952 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No **Baltimore** Director N/A Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2611 Fairview Avenue U.S.A. 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ☐Yes 2 ☐ No ۵ If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify Black 3 ☐ Widowed 4 ☐ Mivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Phillips Seafood, Inc. Cook 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Doris L. Fletcher Alfonso Wynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 Garrison Blvd. Baltimore, Maryland 21216 Tonya Jefferson Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State 11/18/06 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Serv . License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ntracrania disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 1 No 1 Tyes 2□ No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺No 2 1 Thipatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28c. Injury al Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural

Examiner the Hospital or Attending Physicien: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760 detached 24 hours after death.
Funeral Director: After this certifice letely filled in by the funeral director. within 2 ပ္

Funeral

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Depertment of Health and Mentel Hygiene.
Important: If Item 27 ie marked other then 'ne eny injury or other treumatic event, Ite Madig.

Physician

/Medical

Baltimore,

other traumetic event, the Medical Exeminer must be notified at

the Maryland

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

2006

. Name and address of pers pleted/cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 1

29a. Certifier

Medical

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 30A.M 2006 /Medical 4a. Facility Name (Il not institution, give street and number 4b. City. Jown, or Location of Death 4c. County of Death Examiner peakeM ed Conter 5. Social Security Number 6. Se If Under 1 Year Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Months Days Hours Min. Usual Residence of Decedent Yrs Director death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow 27 is marked other then "natural", or iteme 23s or 28s-f shov traumatic event, the Modical Examinar must be notified at 1 Tes 2 No Director 10e. Street and Number 10f. Zip Cod 10g. Citizen of What Country? SA do Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1□Yes 200No Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. nema none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be DWN 19b. Mailing Address (Street and Number or Paral Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health Item 27 MD 21009 20b. Place of Disposition (Name of thinoidon other 20a Method of Disposition

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4 Donation 5 Other (Specify) 20c. Location - City or Town, State Date Important: If It eny Injury or o once. cemetery, crematory or other place 3 □Removal from State Volley Men Gordens 17 LIMONIUM, 21. Signatury of Fyneral and Address of Facility 22. Nan Evanstulierall se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s. List on one cause on each line. 23a. Part1. Enter the diseashock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final Physician spiration disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Examiner anding physicien and use as the burial-transit Due to (or as a consequence of): Sasten Gladys M800255671 Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2 No 1 🗌 Yes 2□ No funeral director. 25. Was case referred to medical 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 **Y** No 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3□ DDA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Medical 🕱 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 7 2006 Registrar

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Division or Vital Records, P.O. Box 68760,	ng Physician: The law requires that the death certificate be executed	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
Division or Vital F	To the Hospital or Attending Physician: The within 24 hours after death.	To the Funeral Director: After this certificate completely filled in by the funeral director, pag

	For	State of	f Marylan		artment of H		and Me	ental Hyg	giene)		
	State Registrar			Cer	tificate of I	Death			leg. No.	200	6	36467
an	Decedent's Name (First, Middle, L.	_ast)						2. Date of Dea Month	Day	/ Yea	ar	3. Time of Death
cal	JOHN			MIA	Ab. City. Town, or	Location		Novems		County of De	060	22
er	4a. Facility Name (If not institution, g		ind - h	1	71	1tim			40.	County of Di	eam	
	5. Social Security Number 6.		7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 2	24 Hrs. 8	B. Date of Birth	1	9. 6	Birthpla	ce (State or Foreign
	212-30-3688	1X M 2□F	92	Yrs.	Months Days	Hours	Min.	(Month, Day -1-19			Country	Greece
	Usual Residence of Decedent		100 000	. Taura and a							1.0	
ř	10a. State 10b. County 10c. City, Town or Location										100	d. Inside City Limits 1 □XYes 2 □ No
ectc	MD		Ba1	timor					10- 01		C	
ä	10e. Street and Number	4-			10f. Zip Code	,				izen of What	Country	y :
Funeral Director	639 Umbra Str 11. Marital Status	_	dent Ever in U.	S. 13. V	2122 Was Decedent of H		nin? (Speci		USA	14. Race - A	mericar	Indian,
Fun	1 Never Married 2 Married	Armed For	rces? 2 No		f Yes, specify Cuba	in, Mexican Specify:	i, Puèrto Ri	ican, etc.)		Black, W		
by	3 Widowed 4 Divorced	If Yes, Giv Year or Da		1	I□Yes 2∏xNo		Specify: White					
Completed	15. Decedent's (Specify only highest of			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						nd of Busine	ss/Indu	stry
mpļ	Elementary/Secondary (0-12)	College (1	-4or 5+))	3					
ပိ	17. Father's Name (First, Middle, La.	ct)		Tai	llor	18 Motho	r'e Name (First, Middle,		othin	ı g	
Be	Apostolos Gia:	,						hrist				
²	19a. Informant's Name/Relationship		<u> </u>	19h Mailin	n Address (Street						e Zin C	(ode)
			C	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State on 38 Mitchell Drive, Abingdon, MD								
	Apostolos Gia: 20a. Method of Disposition	nnas -	20b. P	lace of Dispo	sition (Name of	i	Ve Da			cation - City		
	1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		State I		natory or other plac 1. Cemete	1	11-1	8-06	Ва	1timo	re.	, MD
	21. Signature of Funeral Service Lic											ral Home,
	Det Hach	$ \longleftrightarrow $		PA	2134	Will	ow S	pring	Ro	ad, 2	122	2 2
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											
	Immediate Cause (Final disease or condition											Onset and Death
	resulting in death) Due to (or as a consequence of):									-	5/175	
_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
ine	if any, leading to immediate											
dical Examiner	that initiated events resulting in death) Last	c	or as a consequ	uence of):								
alE			,									
		d										
Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come pf <u>pr</u> egna							23d. Date of	delivery	,
iciaı	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregn	irth 2 □ Feta ant at time of d		Ectopic pregnancy Other (specify)					Month		ay Year
hys	9 □ Unknown	9□Unkno	own									
y P	Part II. Other significant conditions	s contributing to de	eath but not resu	ulting in the ur	nderlying cause giv	en in Part I.		23e. Did to	bacco u	ise contribute	e to the	cause of death?
pe								1 🗆 Y	es 2[□ No 3□	Probal	oly 4 🗹 Unknown
plet								24a. Was a		24b. Were	autops	sy findings available pletion of cause of
Completed by								perfor	med2 2 No	death	1?	□No
Be	25. Was case referred to medical examiner?	I too midaly			To:		of Death (Check only on	ne)			
7	1 ☐ Yes 2 ☑ No		·	ER/Outpatien		4 🗆 Nu		e 5□Resid			pecify)	
iou	27. Manner of Death 1 Natural 5 Pending	,	th, Day Year)	28b. Time of Injury	Wor	/at ⟨? Yes 2∐I		3d. Describe h	ow injur	y occurred		
icat	2 Accident investigati 3 Suicide 6 Could not	be 390 Place	of injury - At ho	me farm str	eet, factory, office	res 2∐I		of Location (S	troot an	nd Number or	- Ruml I	Route Number.
Certification:	4 ☐ Homicide determine	buildi	ng, etc. (Specif)	y)	,		20	City or Tow			rurai i	TOUTO MUNIDON,
S S	29a. Certifier 1 Certifying	Physician: To the	best of my kno	wledge, death	n occurred at the tir	ne, date an	d place, ar	nd due to the c	cause(s)) and manner	as stat	ted.
Medical	(Check only 2 Medical Ex	aminer: On the ba	asis of examina ner stated.	tion and/or in	vestigation, in my o	pinion, dea	th occurred	d at the time, o	date and	d place, and o	due to t	he cause(s)
Me	29b. Signature and title of certifier	.0			29c. Licens	number		2	29d. Dat	te signed (Mo	onth, Da	ay, Year)
	1 (Idam	Tosma	MI		120	5-0	00	10	Vone	mison	216	2006
	30. Name and address of person wh	o completed caus	e of death (Item	23a) (Type,	Print)							ay, Year) Le, 2006 21224
	DR. ADAM POS	SNEW 4	940 E	ASTE	TON AVE	NUE	BA	LTIN	10,2	E, M	7	21224
ite	31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	iture	P							
rar	NOV 1 7	2000	wines.	S. P.	could							

Regis

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Nonth Dav **Physician** 4c. County of Death Henderson elbert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner Baltimore Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 317.30.8706 1**∑**M 2□F Months Days Hours Yrs. Indiana Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a, State or 28a-f show the Medical Examiner must be notified at Baltmone MD 1 XYes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 238 Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 0. Specify: Caucasian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Welder Metal permit. Pages 1 and 2 should be filed will Depertment of Health and Mental Higgien Important: If item 27 ie marked other that any Injury or other traumatic event, Italy once. 10th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Henderson Cordia Northern Herschell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Doris N. Henderson 608 S. Monroe Street Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 □ Burial 2 Cremation 3 □ Removal from State Baltmore 11.15.06 greenmount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign to e of Funeral Service Licensee 22. Name and Address of Facility Compossion Funeral Senice 119-12 5. Stricker Stylet Batto. MD 21223 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oeset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed this certificate 2 No 1☐ Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification; To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death opnumed at the time, date and place, and due to the nause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P 20966 Alsheikh 3 (Item 23a) (Type, Print) Ave, Baltimore 21229 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State 7 2006 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36469 State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Пач Year 8:24 PM HARLOW NOIZMBER 2006 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Hospital Coultimers Johns Hopkins | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov 30, 1957 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months 1 XM 2 ☐ F 218-62-9663 48 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County Yes 2 No Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1033 Elton Avenue 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 3 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Liner Worker Joe Stein & Sons 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Harlow MArtha Verbus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dawn HArlow /wife 1033 Elton Avenue Baltimore MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory 11/17/06 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 MAce Ave.Balto. MD 21. Signature of Funeral Service License Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TEAR GNOSTACE LIVER DISEASE Due to (or as a consequence of): CHRONIC PANCREATITIES Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Year use of death? 4 MUnknown indings available

Physician /Medical Examiner Examine

Department of H Important: If Its any Injury or of once.

Physician

Examiner

Funeral

Director

r than "naturel", or Itema 23a or 28a-f show the Medical Exampler must be mutilied at

Pages 1 and 2 should be filed within 72 hours atternent of Health and Mental Hygiene.
ant: If Item 27 te marked other than "naturel", or Ite

Baltimore, Maryland 21215-0036

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nding physicien end use as the burial-transit To the Hospital or Attending Physician: The law requires thet the death certificate be executed USB as been signed by the should be deteched page 2 s certificete After thi funeral of death. within 24 hours after death To the Funeral Director: completely filled in by the

Physician/Medical

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Be Completed

Certification; To

Medical

4 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Qay) Year

Stephen

29a. Certifier

Division of Vital Records, P.O. Box 68760,

	d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	il death 3 □Ecto	pic pregnancy er (specify)		23d. Date of delivery Month Day
Part II. Other significant conditions of	ontributing to death but not res	sulting in the underh	ying cause given in Part I.	23e. Did tobacco	use contribute to the car 2 No 3 Probably
				24a. Was an autopsy performed?	
25. Was case referred to medical			26. Place of D	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	□ DOA Dther: 4 □ Nursing	Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in	ury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h	ome, farm, street, f	actory, office	28f. Location (Street	and Number or Rural Rou

t 🖄 Contifying Physician: To the best of my knowledge; death conumed at the time, date and plane, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DBS-000

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MO

N 7 2005 32. Registrar's Signature

WOLFE

MIC

560

30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print)

6

X. TANG

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

WOVENBER 13, 2016

MARTEND 21287-9106

State Registrar

DHVH 17 Rev 1/200

State of Maryland / Department of Health and Mental Hygien & UUb 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 15 - 06 MATH: OO HASTY NOV-MELVILLE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia dar 1 Year | If Under 24 Hrs. Howard County General Hospital 8. Date of Birth (Month, Day, Year) June 16,1933 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1**X** M 2□ F Months Hours 73 Yrs. Director Maine 004-32-2168 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State ui Hygiene. I other then "natural", or fleme 23a or 28e-f show vent, the Medical Examinar must be notified at 1 ☐ Yes 2 🗓 No Hudson Directo Floroda Pasco the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10421 Tami Trail 34669 **USA** deeth Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deet. Department of Health and Mental Hygiene. Importent: If ten 27 is marked other than eny injury or other traumer. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠ Yes 2 □ No 1954

If Yes, Give Year or Dates: 1957 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive Repair 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marston Hasty Unknown ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10421 Tami Trail Hudson, Florida 34669 Dorothy B. Morency, Legal Rep 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/15/06 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Cognises
Thomas Gregor Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE HOURS Physician HYPOXIC /Medical Due to (or as a consequence of) Examiner Z HOURS PNEUMOTHORAX Supernitally flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit SEPTIC SHOCK HOURS nding physiclen and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 12 Hours PERFORATED Physiclan/Medical DIVERTICULI use as the IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by been signe should be OBSTRUCTIVE PULMONARY CHRONIC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Haknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an cate hes page 2 s certificate 1☐ Yes or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural Injury 5 Pending within 24 hours efter death.

To the Funarel Director: Af 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 00063147 NOV 15, 2006 30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print) CEDAR LANE, COLUMBIA MD LEFFREY B. HOAG HCGH 5755 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 7 2005 Registrar

DHMH 17 Rev 1/2001

06-08711 Donald Head Please Type or Print in Black Indelible Ink

Manyland / Department of Health and Mental Hygiene

onalo neao		5tate of Maryland		cate of Death	and Mental r		1 No. 200	6 3647
Physicia	in/	1. Decedent's Name (First, Middle,Last)				2. Date of Death	410	3. Time of Death 2132 hrs
/ledical Exami /	ner	Donald Lee Head 4a. Facility Name (if not institution, give street and number	1)	4b. City, Town	or Location of Deat	Month November	15, 2006 4c. County of Dear	
		Saint Joseph's Medical Center	,	Towson			Baltimore Co	
Funeral Director		220-30-1792 1XM 2 F	ge (In yrs. last b		Year If Under 24Hr Days Hours Mil	_	1935 Fore	
any	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	vn or Location				10d. Inside City Limits
daryland 28a-f show any 1 at once.	ě	Maryland Baltimore		Balti	more			1 Yes 2 X No
oith the Maryland 23a or 28a-f shov	I Director	10e. Street and Number 8 Juliet Lane, Unit 203		10f. Zip Cod	e 21236	100	g Citizen of What Coi	untry?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "matural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Force: 3 Widowed 4 X Divorced If Yes, Give Year		13. Was Decedent of If Yes, specify Cu	ban, Mexican, Puert		White, etc.	rican Indian, Black, Uhite
ours aft atural" camine	d by	15. Decedent's Education (Specify only highest grade co	mpleted) 16a	a. Decedent's Usual Occu	pation (Give kind of		16b. Kind of Business	
21215-0036 Uld be filed within 72 hours a Mental Hygiene. nnarked other than "natura e event, the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 o		during most of working Salesman			Auto Deal	ership
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medical	Be Co	17. Father's Name (First, Middle, Last) Gilman E. Head				ie (First, Middle, Mi illian Wi	,	
2121 rould be fi d Mental is marked tic event,	To E	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (S				
ages I and 2 shount of Health and Nat: If item 27 is not other traumatic		Donna Torbit (daughte		2000 Falls e of Disposition (Name of			20c. Location - City o	
imore, MC Pages 1 and 2 s ment of Health at tant: If item 27		1 X Burial 2 Cremation 3 Removal from S	late	latory or other place) Lawn Cemete	ru 11.	/20/2006	Baltimore.	, Maryland
Baltimore, MD 21215-00. permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other it injury or other traumatic event, the Mec		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Ouic	22. Name and Add	ress of Facility Sc	rimunek F	uneral Hor	nes
Physician	\dashv	23a. Part I. Enter the disease, or complications that cause	d the death. Do				e, MD 2123 st, shock, or heart	Approximate Interval
/Medical Examiner			Disease co	omplicated by blood	loss from dislo	odged femoral	catheter	Between Onset and Death
		or condition resulting in death) Due to (or as a con	sequence of):					
	iner	if any, leading to immediate Due to (or as a con	sequence of):					
J. 2 . 2	Examiner	(Disease or injury that initiated events resulting in death) Last	sequence of):					
760, cate be executed physician and he burial - transit	Medical I	d. UNPENDED AMENDED						
760, icate be physicate the burn		IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the	me of pregnanc		o		23d. Date of delive	-
Box 687 The death certifice The attending properties to the control of the cont	Physician	past 12 months?	at time of death	Fetal deathOther (Specify)	3 Ectopic pregr	nancy	Month	Day Year
O. Bo t the dea by the a	Phys	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to dea	th but not resul	ting in the underlying cau	se given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ires that the signed by	þ	Hypertension				1 Yes	2 No 3 Pro	bably 4 Unknown
ords, w requii	Completed					24a Was ar autops	y prior to	utopsy findings available completion of cause of
Vital Recol	Com					perform 1 Yes 2		'es 2 No
Vital ysician: his certil director	o Be	25. Was case referred to medical examiner? 1 V Yes 2 No Hospital: 1 I I Inpar	ient 2 ER	/Outpatient 3 DOA	Other Nurs		Residence 6 Othe	ər:
Division of Vital Records, ral or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	-	27. Manner of Death 28a. Date of Ir	iury 28t	b. Time of Injury 28c.	Injury at Work?	28d. Describe ho	ow injury occurred	
Sion Attend r death. ector: by the t	catic	2 Accident Investigation Nov 15, 200	6 21	08 hrs 1	Yes 2 No		reet and Number or R	ural Route Number, City
Division pital or Attent ours after death teral Director: filled in by the	Certification:	3 Suicide 6 ✓ Could not be determined (Specify) H		i tarrii, orroot, taolory i orri	oo banang, oto.		ate) Medical Center, To	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certification of the Toneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical C	29a. Certifier (Check only) Medical Examiner: On the basis of examt manner state.	amination and/o					
F 3 F 3	Me	296 Signature and title of certifier			ense number		29d. Date signed (M	
	((Outabelle	1-1-1-11		.C.M.E.		November 16, 2	2006
10		30 Name and address of person who completed cause of Laron Locke MD. Assistant Medical E.		11 Penn Street, Ba	altimore, MD 21	201		
S			rar's Signature	in America	-			
Regis	11:11	MOV 1 7 2008 32	. w	D . C. C. C. C. C. C. C. C. C. C. C. C. C				

				pe or Print in i State of Marylar					-			0.61.70
			for State Registrer	hate or warylar			of Death			eg. No.	006	36472
	9		Decedent's Name (First, Middle, Last)						2. Date of Dear		Year	3. Time of Death
	Physicia /Medic			Houck					Novembe	r 10	, 2006	1:27P M
	Examin		4a. Facility Name (If not institution, give stre			4b. City, To	own, or Location			4c. C	County of Deat	n
		٠	4816 E. Hoffma 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Balti Year If Unde		8. Date of Birth		9. Birtl	nolace (State or Foreign
	Funeral Director			1 2⊠F 91	Yrs.	Months		Min.	8. Date of Birth (Month, Day) July 21	Year) 19	15 Wes	nplace (State or Foreign untry) t Virginia
	D.		Usual Residence of Decedent 10a, State 10b, County	100 0	ty, Town or Lo							10d. Inside City Limits
	be filed within 72 hours after death with the Maryland the thygiene. All the Widel of other than "natural", or flems 23a or 28a-f show avant, the Medical Exercit arrival te notified at	ō		100. 01	ty, town or Ec		timore					1 X Yes 2 No
	28a-	Director	Maryland N/A 10e. Street and Number			10f. Zip C			1	0g. Citiz	en of What Co	untry?
	h with		4816 E. Hoffman St.				21205				u.s.	Α.
	deatl	Funeral	11. Marital Status 12.	Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decede			ecify Yes or No- Rican, etc.)	1.	4. Race - Ame Black, White	rican Indian,
2	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give			No Specif		,		2	White
2-003p	hours tural'	q pa	3 X Widowed 4 □ Divorced 15. Decedent's Educat	Year or Dates:	16a Dece	dent's Usual	Occupation			16b. Kin	d of Business/	
Ċ	within 72 hours after ene. than "natural", or Ite is Medical Exeritiral	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work DO NOT use	done during me	ost of worki	ng			,
7	ed with	Com	12th Grade			Qua	lity Co				Glass (Company
/land	be filed tal Hygie d other avant, II	Be	17. Father's Name (First, Middle, Last)				18. Mot		(First, Middle, I		Sumame)	
	2 should and Men Is marka aumatic	To	Warren L. Perfater 19a. Informant's Name/Relationship (Type,		10h Maili	ng Addross /	Street and Num		M. Ton		Town State 7	in Code)
Z Z	12 7 Is		Frederick Hensen (S			,						Md. 21237
ē,	othar		20a. Method of Disposition	20b.	Place of Dispo	sition /Name	of				ation - City or	
Ē	permit. Pages 1 and Department of Healt Important: If itam 2 any injury or other once.		1	Go								Maryland
Saitimore	permit. Departi Import any inj once.		21. Signature of Juneral Service Licensee	(imunek i			
	20 5 8 0		23a Part Enter the disease or complia	tions that caused the dea					altimor		acycano	Approximate
	Dharaisian		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consect Or or or or or or or or or or or or or or	quence of):	2+41	(4127	ı				in modiate
	Examiner		Sequentially list conditions b	Coronar	y he	24-+	dise	Lse	·			years
	be sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):							
	xecut and al-tran	Examiner	that initiated events c resulting in death) Last	Due to (or as a consec	quence of):	<u> </u>			· · · · · · · · · · · · · · · · · · ·			
) PO	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	calE	d			·						
9	w requires that the death certificate been signed by the attending phys should be detached for use as the	by Physician/Medl	IF FEMALE:									
X Q	ath ce ttendi or use	jan/l	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregn 1☐Live birth 2☐Fet	al death 3	Ectopic pre				2:	3d. Date of deli Month	ivery Day Year
	the de / the a ched f	ysic	1 □ Yes 2 No 9 □ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5L	Other (spe	ciry)					
<u>.</u>	that the ned by a deta	y Ph	Part II. Other significant conditions contri		sulting in the u	nderlying car	use given in Par	t I.	23e. Did to	bacco us	e contribute to	the cause of death?
Vital Records,	aquire: en sig ould b	ed b	Dementia	\					1 🗆 Y	es 2	No 3□Pr	obably 4 Unknown
ecc	law re as be	Completed						·	24a. Was a	y	prior to o	topsy findings available completion of cause of
Y		Con							1 Yes	No No	death?	2□ No
N N	Phyaician: The law this certificate has I ral director, page 2 s	Be	25. Was case referred to medical examiner?	spital:	7.550		Other		(Check only or		Cloubs 10s -	-:4.1
	p Phys er this eral di	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o		c. Injury at Work?		me 5 Reside 28d. Describe he			city)
<u>0</u>	anding ath. or: Afte	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	1 Yes 2	□No				
DIVISION OF	tal or Attanding Ph is after death. al Diractor: After the ed in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, st ify)	reet, factory,	office		28f. Location (Si City or Town		Number or Ru	ıral Route Number,
_	pital ours a laral Claral Claral Clilled i		29a Certifier Certifying Physic	ian: To the best of my kn	owledge, deat	h occurred a	t the time, date	and place.	and due to the c	ause(s) a	and manner as	stated.
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Examinations)	r: On the basis of examin and manner stated.	ation and/or in	vestigation, i	n my opinion, d	eath occurr	ed at the time, d	ate and i	place, and due	to the cause(s)
	To the Hospital or I within 24 hours after To the Funeral Direct completely filled in b	M	29b. Signature and title of certifier	à			License numbe				signed (Monti	
			Rodney to	nk, ~,			17 X 3	436		V & V	en boc	14, 2006
	5		30. Name and address of person who com		m 23a) (Туре,	Print)	Ano =	use s	361+20	000	han	14, 2006 2(213 yland
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	A	PICH	(V		1	1-1-1	7 1-12
	Regist		NOV 1 7 200	16	Ag A	English.	9					

			For State Registrar	State	of Mary	land /	Depa <i>Cer</i>	rtmen tificat	t of H e of L	ealth and N Death		Reg. No.		36473
	Physicia	an	1. Decedent's Name (First, Middle, Last,								2. Date of De Month Novemb		í, 2ď0	3. Time of Death
	/Medic			Z. Had				Ab City	Tour or	Location of Death			County of De	
	Examin	er	4a. Fecility Name (If not institution, give Suburban Hospital		umber)			40. Oily,		Bethesda		10.	,	gomery
	Funeral		5. Social Security Number 6. Sec		7. Age (In	yrs. last b	oirthday)	If Under	1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	rth Zu Voarl		irthplace (State or Foreign
×	Director		577 - 88 - 7191]M 2⊠F		97	Yrs.	Months	Days	Hours Min.	April 1	2, 1	.909	Syria
	p .	ļ	Usual Residence of Decedent 10a. State 10b. County		10	c. City, To	wn or Lo	cation						10d. Inside City Limits
	ehov	5		*37		c. Ony, 10		ockvi	110					1 ☑ Yes 2 ☐ No
	the N	Directo	Maryland Montgome 10e. Street and Number	ГУ			K	10f. Zip				10g. Citi	izen of What (Country?
	3a or		615 Muriel Street							20852		Unit	ed Sta	tes
	death	Funeral	11. Marital Status	12. Was Dec	cedent Ever	r in U.S.	13. \	Was Dece	dent of Hi	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No	o-	14. Race - An Black, Wh	nerican Indian,
9	after or its		1 Never Married 2 Married		2 🔀 No		1	i □ Yes		Specify:	, , , , , , , , , , , , , , , , , , , ,			hite
Maryland 21215-0036	within 72 hours after death with the Maryland ene. Then "neturel", or iteme 23e or 28e-f ehow the Madical Exeminer mast be notified at	d by	3 ☑ Widowed 4 □ Divorced	Year or	Dates:	10	- D	tanta Hau	-1 0	-tian		16h Ki	ind of Busines	
5	"net	lete	15. Decedent's Edu (Specify only highest grad	e completed			(Give	lent's Usu kind of wo DO NOT u	rk done d se retired	during most of won)	king	100. KI	ind of Dusines	amoustry
72	withi	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)			emake					Own Ho	me
פַ	e filed Il Hygid other vant, Il	BeC	17. Father's Name (First, Middle, Last)							18. Mother's Nam	ne (First, Middle	, Maiden	Sumame)	
/lar	should be ind Mental markad o umatic eva	ToE	Najeeb Nassir	n							amina S			
an	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene 7. Hours 16 marked other then "neturel", or iteme 23e or 28e-1 ehow other traumatic event, the Madical Examinar mast be inclifted at		19a. Informant's Name/Relationship (7)			1		•		and Number or Ru				, Zip Code)
2 oî	and fealth m 27		S. John Haddad/Son	1		17 20b. Place				d Drive, Ol	ney, Mar		cation - City o	or Town. State
Š	ages 1 to tr if ite or ot		1 Burial 2 ☐ Cremation 3 ☐ F			Gat	tery, crer e OI	natory or d Hea	ther plac ven	ı ı	mber 17,		10	
altimore,	iit. Pe artmer ortant injury i.		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Ucens		1		Ceme	tery . Name a	nd Addres	ss of Facility Roll	006 Dert A.	Pump	hrey F	ing, Maryland uneral Home/
Ba	permit. Peges 1 and 2 Depertment of Health a Important: If Item 27 le eny Injury or other trat) / M		мо	1473	Ro	ckvi.	lle,	Inc., 30	00 W Ma 1 20850-	ntgō -2805	omerý A	uneral Home/ venue,
			23a. Pakil. Enter the disease or comp shock, or heart failure List only of	lications that	caused the									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SF	TO le	2								2 olary
	/Medical		resulting in death)	Due to	o (or as a co	onsequenc	e of):							1
ı	Examiner		Sequentially list conditions,	b										
	₩ / E	Examiner	Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a co	onsequenc	e of							
	and Autran	хап	that initiated events resulting in death) Last	c. Due to	o (or as a co	onsequenc	e of):							
8760,	ficate be executed physicien and s the burial-transit	dlcal E		d										
687	ificate g phy as the	edic		u.								1-		
. Box	The law requires that the death certifi sie hes been signed by the attending i page 2 should be detached for use as	Physician/Me	23b. was decedent pregnant	23c. If yes, o 1⊟Live	outcome of p		ath 3[Ectopic p	regnancy				23d. Date of d Month	lelivery Day Year
	s deat he att	sicie	in the past 12 months? 1 □ Yes 2X No		gnant at tim			Other (s)				4	WOITH	Day 16a1
<u>Ч</u>	d by t	Phy	9 Unknown Part II. Other significant conditions co	etributing to	death but n	ot resulting	n in the u	nderlying	ause div	en in Part I	23e. Did	tobacco i	use contribute	to the cause of death?
ds,	w requires that been signed I should be det	1 by	Partil. Office significant obtained	i kinbaking to	GGGGG GGG		9				10	Yes 2	£(No 3□	Probably 4 Unknown
Š	v requ been shouk	etec									24a. Wa	s an	24b. Were	autopsy findings available
Rec	The lav	Completed									auto	opsy formed?	death'	
tai		0	25. Was case referred to medical							26. Place of Dea			1 □ Y	es 2 No
<u>=</u>	S S D	To B	examiner? 1 ☐ Yes 2 ∰ No	Hospital:	Inpatient	2 🗆 ER/	Outpatier	nt 3 D	OA Oth	er: 4 🗆 Nursing H	iome 5 🗆 Res	idence	6 □Other (S)	pecify)
0	Attending Physicien: r death. sctor: After this certific by the funeral director.	ü	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Dat (Mo	e of Injury onth, Day Y	9 <i>ar)</i> 28t	o. Time o Injury	f	28c. Injur Wor	y at k?	28d. Describe			
Sio	eath. or: A	catle	2 Accident investigation					М		Yes 2 □ No	004 1	(C4 4	d 8 (0
Division of Vital Records, P.O	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	280. Pla	ce of Injury Iding, etc. (- At home, Specify)	, farm, sti	reet, facto	y, office			own, State		Rural Route Number,
_	portei portei filled		29a: Certifier 120 Certifying Phy	raician: To t	ha best of ri	ay knowled	dge deat	h Undumed	at the ti	e date and place	i, and due to the	i calisa(si) and manner	as stated
	To the Hospitel or Attending Ph within 24 hours effer death. To the Funeral Diractor: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exam	iner: On the	basis of ex anner stated	amination	and/or in	vestigatio	n, in my o	pinion, death occu	irred at the time	, date and	d place, and d	ue to the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier	1/1				29	c. Licens	e number		29d. Da	ite signed (Mo	onth, Day, Year)
			Jeors 1	120			_	1	10	06033	3	11/	11/0	6 4 AM
	4		30. Name and address of person who of Subjudgm 10. 31. Date filed (Month, Day, Year)	ompleted ca	u e of deat	h (Item 23	a) (Type,	Print) G	eorg	Aue, MD	ed D	, 71.	ocat a	MO
	· ·		31 Date filed (Month, Day Year)	2010	Registrar's	Signature	UUI.	000	Je si	ion hou	10, 8.	C 040	->-(-(7-10
18	Sta Regist		NAV 1 7	2006	1000	1131	A.	loo	A STATE OF					

Haddad, Rose Z. 11/11/06 0345

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene

4b. City, Town, or Location of Death

Chevy Chase

12, 2006

4c. County of Death

Montgomery

United States

14. Race - American Indian,

Black, White, etc.

16b. Kind of Business/Industry

Education

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

November 13, 2006

Month

2. Date of Death

November

5:15

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

Virginia

Black

Physician /Medical Examiner 1 - State Registrar

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Manor Care-Chevy Chase

William Holloway

State Registrar DHMH 17 Rev 1/2001 32. Registor's Signature

Susan Miller, M.D. 6844 Tulip Hill Terrace, Bethesda, Maryland 20816

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

D35579

			For State Registrar		State o	of Maryland	d / Depa <i>Cei</i>	artment <i>tificate</i>	of He	ealth a Death			Reg. N		6	364	75
	Dhysisi		1. Decedent's Name (First, A	fiddle, Las	t)							2. Date of De Month	Di	ay Y	ear	3. Time of	
	Physici /Medio		Thomas Mic									Novemb		12 , 20		7:55	Рм
-	Examir	er	4a. Facility Name (If not insti					4b. City, T			t Death			C. County of			
re.			Potomac Vall 5. Social Security Number	ey Ni		Home 7. Age (In yrs. Ia	est hirthday)	If Under 1	ckvi Year	.TTE	24 Hrs. p	Date of Bi		Montgo		/	or Foreign
К	Funeral Director				X M 2□F	80	Yrs.		Days	Hours	Min.	Date of Bi (Month, Di		1926		ace (State o	, , , , , ,
4			206-12-3583 Usual Residence of Deceder	it		- 00						OCL.		1920 1			
	how		10a. State 10b. Co	unty		10c. City,	, Town or Lo	cation							16	d. fnside Ci	
	Sa-fs	Funeral Director	Maryland Mo	ntgom	ery	Po	tomac									1 🗌 Yes	26X140
	ith th	Dire	10e. Street and Number	0				10f. Zip 0	Code				10g. C	itizen of Wha	at Coun	try?	
	ath w	rai	9013 Marsei	lle D	rive	edent Ever in U.S	10.1	20 Was Decede	854	ania Osia	nie? (Cnoo	tu Voc or N		ted S1			
	Item Item	nue	11. Marital Status 1 □ Never Married 2 🔯	Married	Armed Fo	orces?		f Yes, specif	y Cubar	n, Mexican	, Puerto Ri	can, etc.)	0-		White,		
336	hours after death with the Maryland lural', or itema 23a or 28a-f show al Examinar must be notified at	þ	3 ☐ Widowed 4 ☐ Divo	1	If Yes, Gi Year or D	ve World	a TT	1□Yes 🏖	No D	Specify:				Specify:	hite		
5-0036	72 hor	Completed	15. Dec (Specify only I	edent's Ed	ucation	1	16a. Dece	dent's Usual kind of work	Occupa	ition	of working	7	16b.	Kind of Busin			
21	within 7 ene. then "r	nple	Elementary/Secondary (0-		College (life.	DO NOT use	retired))		,	Pe	trole	um		
21	ed wi	Co			4		I	Lobbyi		40.11-15-	-t- No (Fire A. Adiabatic		mpany n Sumame)			
pu	be fill H doth	Be	17. Father's Name (First, Mic											n Sumame)			
Z	should be filed within and Mental Hygiene. marked other than "umatic event, the Mag	2	Charles J.				10h Mailir	a Address /	Street a			et Cla		or Town, St	ate Zin	Code)	
Maryland	nd 2 sho alth and 27 is m					Ji fo		250980d						Maryla		2085	4
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mantal Hyglene. Item 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at		Mary Kathlee 20a. Method of Disposition	u neu	nessy/	20b. Pla	ace of Dispo	sition (Name	e of		Da	te		_ocation - Ci			T
lon I			1 X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			State Gat	e of I	leaven	ler piace	ILLY	ovemb 2006	er 17	C+1	ver S	one i v	o Mi	
altimore	permit. Pages 1 a Department of Hei Important: If item any injury or othe once.		21 Signature of Francial So	vice Licen	A	21	Cenic	Name and	Addres	s of Facility	v Roh	ert A	P_1	mphre	v Fi	meral	Home
ñ	Depa Impo any is		23a. Part 1. Enter the disease	:JE.	سرها	→ MOO	803 I	Rockvi	lle	, Inc	. 300	West	Mor	tgome:	ry A	venue	
15			23a. Part1. Enter the diseas shock, or heart failure.	e, or comp	olications that	caused the death.	. Do not ent	er the mode	of dying	such as	cardiac or	respiratory a	arrest,	.005			
	Physician		Immediate Cause (Final disease or condition				MEN	AIT								Onset and	Death
7	/Medical		resulting in death)		Due to	(or as a consequ	ence of):										
-	Examiner	(Sequentially list conditions,	- 1		ENTR		NTZ	=	130	2112	DITA	2				
	be tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due to	(or as a consequ	ence of):										
٠_	and and Il-tran	хап	that initiated events resulting in death) Last	1	c	(or as a consequ	ence of):								-		
8760,	be e sician buria			·	4												
687	eeth certificate be executed attending physician and for use as the burial-transit	Physician/Medical		-	u.												
Box	anding use a	Z/M	IF FEMALE: 23b. Was decedent pregnar	it		tcome of pregnar		Ectopic pre	ananc)(23d. Date		,	
	D O D	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No			nant at time of de		Other (spe						Month	1	Day	Year
P.O.	± ≥ %	hys	9 🗆 Unknown									T					
	w requires that the been signed by th should be detache	by F	Part II. Other significant co	nditions co	ontributing to c	leath but not resu	Iting in the u	nderlying ca	use give	n in Part I.				use contribu		e cause of c abiy 4 ⊡1	
ord	equir sen s	ted											Yes 1				
Ö	4 3 CA	Completed										24a. Wa:		24b. We	re autor or to cor ath?	sy findings apletion of c	available ause of
E	The ete	Co										1 Tes			Yes	200 No	
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to me examiner?	-	Hospitaf:				Othe			Check only					
of	Q 12.	. To	1 Yes 2 No		1	Inpatient 2 E	28b. Time o							6 Other		")	
o	ding F h. After tuner	tlon	1 ⊠Natural 5 □ P	ending vestigation		of Injury oth, Day Year)	Injury	М	c. fnjury Work	:? ∕es 2 🔲 I				,			
Division of Vital Records,	Attending r death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ C	ould not be	28e. Plac	e of Injury - At hor	me, farm, st	eet, factory,	office		28			and Number	or Rura	Route Nun	nber,
ō	spital or Attending Phous after death. eral Director: After th	Certification:	4 Homicide	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	build	ling, etc. (Specify)					City or To	iwn, Sta	(e)			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifier (Check only 2 Merone)	tifying Ph	iner: On the b	e best of my know basis of examinationer stated.	wledge, deat ion and/or in	h occurred a vestigation,	t the tim	e, date an pinion, dea	d place, an	d due to the	cause(s) and mann nd place, and	er as st	ated. the cause(s	s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of c	entifier	1	10		29c.	License	number			29d. D	ate signed (Month, I	Day, Year)	
					X		, X		4	00	512	-80		11-18	د- ;	OC6	
~	125		30. Name and address of pe	son who				Print)									
	13		Anushiravan		D.O.	9715 Med	lical	Center	Dr	ive,	#201,	Rock	vil]	Le, MD	20)850	
	Sta Regist	ate rar	31. Date filed (Month, Day, NOV	1 7 2	006 32.	9715 Med Registrar's Signat	ure.	seed s									

			State of Maryla	and / Depai <i>Cert</i>	rtment of F	lealth and <i>Death</i>		gien e () () Neg. No.	16 36476
		1. Decedent's Name (First, Middle, Last)					2. Dete of Dea Month		3. Time of Death
	Physician /Medical	George Francis	Hof				Novembe		006 12:15a
	Examiner	4a Fecility Neme (If not institution, give					r Location of Death	4c. County	
1_		Continuum Care A				Sykesvi		Carı	
ı	Funeral Director	5. Sociel Security Number 6. Security 1116	7. Age (In)	rs. last birthday) Yrs.	Months Days	If Under 24 Hi Hours Min		Year) 8 1931	Birthplace (State or Foreign Country) MD
	p.	Usual Residence of Decedent	100	City, Town or Loca	ntion				10d. Inside City Limits
	Maryla fradat	10a. Stete 10b. County Howard		est Frier					1 ☐ Yes 2 ☐ No
	ufter death with the Me r Here 23e or 28e-f's river must be notified Funeral Director	10e. Street end Number 13811 Route 144			10f. Zip Code 2179	4		10g. Citizen of V USA	Vhet Country?
98	72 hours after death with the Meryland natural", or items 23s or 28s-f show dical Examiner must be notified at steed by Funeral Director	1 Never Married 2 Married	HAKAS GIVA	1951-	as Decedent of H Yes, specify Cuba		(Specify Yes or No- erto Rican, etc.)	Blac	e - American Indian, k, White, etc. White
8	ural'.	3 ☐ Widowed 4 ☐ Privorced	Year or Dates:	1955			-	16b. Kind of Bu	
21215-0036	lad within 72 hours e tygiana. her than "natural", o nt, the Medical Exar Completed by	15. Decedent's Educ (Specify only highest grade	e completed)	(Give ki	nt's Usual Occup ind of work done O NOT use retired	during most of w d)	orking	16b. Kind of Bu	sinessindustry
212	then the	Elementary/Secondary (0-12)	College (1-4or 5+)		iter tec	_		compu	ıter
land	Mantal Hygurked other artic event,	17. Father's Neme (First, Middle, Last) George Cyrus Hof					ame <i>(First, Middl</i> e, n M. Jenel		θ)
Maryland	nd 2 shou lith and M 27 is mer r traumet	19a Informant's Name/Relationship (Ty Lisa Hof (daughter	pe, Print)				Rumel Route Number Friendsh		
Baltimore,	parmit. Peges 1 and 2 should be filad within 72 hours aftar death with the Meryler Dapartment of Haalth and Mantal Hygiana. Important: if Item 27 is marked other than "natural", or Nems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified a pace. To Be Completed by Funeral Director	20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)		Place of Disposi cemetery, crema arrison F			Date 11-21-06		City or Town, State Mills, MD
Balti	pamit. Dapartri Importa any inju	21. Signature of Funeral Service License Page Haight	Herbert	22. P.	Name and Addre	ss of Facility 195 Syke	laight Fur esville, N	neral Ho MD 21784	ome & Chapel
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the d	eeth. Do not enter	the mode of dyir	ng, such es cardi	ac or respiratory ar	rest,	Approximate Interval Between
1	Physician /Medical	Immediate Cause (Final disease or condition					isease		Onset and Death
	Examiner	resulting in death)		o (or as a consequ					
0,	igned by the attending physician end be deteched for use as the bunist-transit by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to) (or as a conseque	ence oly.				
68760,	ufficeta by ng physici es the bu	that initiated events resulting in death) Last	Due to	o (or as a conseque	ence of):				
Вох	th car tandir or usa		l		-				
	a daeth tha attar hed for u	Part II. Other significant conditions con	tributing to death but not	resulting in the unc	derlying cause giv	en in Part I.	23b. Did to	obacco use cor	ntribute to the cause of death?
, P.O	that the sed by detect						101	res 2□ No	3 □ Probably 4 □ Unknown
of Vital Records,	bean s should						24a. Wes e perfor		24b. Were eutopsy findings available prior to completion of cause of death?
æ	The law sta hes pege 2						1 🗆 Y	es 212 No	1 ☐ Yes 2 ☐ No
ita	ysician: Tha i s cartificata he diractor, pege To Be Com	25. Wes case referred to medical examiner?				26. Place of D	eeth (Check only o	ne)	
Ž	Physician: this cartific ral diractor,	1 ☐ Yes 2 ☑ No		ER/Outpetient	3□ DOA Oth	4ES Nursing	Home 5 ☐ Resid		
ion	Attending Pi ir daath. Octor: After ti by tha funers iffication:	27. Manner of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accidentinvestigation	28a. Dete of Injury (Month, Dey Year	28b. Time of Injury	28c. Injur Wor M 1 □	yat k? Yes 2∐No	28d. Describe h	ow injury occurr	ed
Division	e E E	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp.	t home, farm, stree ecify)	et, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
	To the Hospital within 24 hours To the Funeral complately filled Medical C	29a. Certifier 1 ☐ Certifying Phys (Check only one) 1 ☐ Medicat Examir	niclan: To the best of my ner: On the basis of examand manner steted.	knowledge, death of investigation and/or investigation	occurred at the tirestigation, in my o	ne, date end pla pinion, death oc	ce, and due to the c curred et the time, c	cause(s) end ma date and place, a	nner as steted. and due to the cause(s)
	Vithin To the comp	29b. Signature end title of certifier			29c. Licens	e number		29d. Date signed	(Month, Dey, Year)
	1)	30. Name end address of person who co		0 0	rint)	1 W/	e itmin	inter 1	MD 22157.
	State	31. Dete filed (Month, Day, Yeer)	32. Registrer's Si	gnature	e ruce		-317		3 /
	Registrar	MAT X SOO	D A	22	100				

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	\cup		- 4	

		1	1 - Stata Registrar			Certificate of	Death	Re	eg. No.		0011.
	Physici		1. Decedent's Name (First, Middle, Las EDWIN	()	LEE	HERMAN	٧	2. Date of Deat Month November	h Day	Year 2006	3. Time of Death 4: 42 AM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		_	nty of Death	
	LXaiiiii	ζ'	SINA HOSPITAL OF	BALTIMORE		BALT	TMURE CI				N/A
	Funeral Director		5. Social Security Number 220-14-8006 6. Security Number 1.		(In yrs. last birth			8. Date of Birth (Month, Day, 09/02,	/1926	9. Birth Cou	place (State or Foreign ntry) MD
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	farylan Febow	ō	MD N/A		D	ALTIMORE					1 Ves 2 □ No
	the h	rect	10e. Street and Number			10f. Zip Code		1	0g. Citizen o	of What Cou	intry?
	3a or	□	3211 CLARKS LANE	APT. 204		2120	q				USA
	death ms 2	Funeral Director	11. Marital Status	12. Was Decedent E Amed Forces?	ver in U.S.	13. Was Decedent of I		pecify Yes or No-		ace - Ameri	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23e or 28e-1 ehow event, the Medical Examination that it willed at	by	1 🛣 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	∘ WWII NAVY	1 ☐ Yes 2 💢 No	Specify:	, , , , , , , , , , , , , , , , , , ,	Spec		WHITE
5-0	72 hc	Completed	15. Decedent's Ed (Specify only highest gra		1 1	Decedent's Usual Occup (Give kind of work done	during most of work		16b. Kind of	Business/Ir	ndustry
121	within ene. than "	ďω	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NOT use retire	d)		HOME	TMDD∩	VEMENT
	Hygie Hygie other t		17. Father's Name (First, Middle, Last)		3	ALLS	18. Mother's Nam	ne (First, Middle, M			VENENI
land	should be filed withir and Mental Hygiene. marked other than imatic event, the M	To Be	RALPH		Н	ERMAN	ANNA				LEVY
Maryland	nd 2 stallth ar		19a. Informant's Name/Relationship (7			Mailing Address (Street SLADE AVEN					p Code) 208
Baltimore,	Pages 1 ar		20a. Method of Disposition 1		cemetery	Disposition (Name of r, crematory or other pla AAKOV BETH	се)		20c. Locatio	n - City or T	
altir	- EEE		21. Signature of Funeral Service Licen			22. Name and Addre		OL LEVINS			
ä	permi Depart Impor		Koto /c	from	\geq	8900 REIS	STERSTOWN				
Ì	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. ACUTE Due to (or as a	e. PENAL for consequence of the	FANURE f):	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed at has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Medical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	0.	Consequence o						
Box	ne death certif the attending thed for use a	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 1 4 ☐ Pregnant at 19 ☐ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у			Date of deliv Month	rery Day Year
P.0	that the od by detac	Ph	Part II. Other significant conditions of	ontributing to death bu	it not resulting in	the underlying cause gr	ven in Part I.	23e. Did tot	oacco use co	ontribute to	the cause of death?
ds	w requires that been signed to should be det	d by	HYPERTENSION)				1 □ Y€	es 2□No	3 □ Pro	bably 4 Honknow
Division of Vital Records,	The law rec te has bee age 2 shou	Completed						24a. Was a autops perform	n 24 iy ned? 2 14 No	b. Were aut prior to co death? 1 Yes	opsy findings available ompletion of cause of
ital	lcian: Th certificate ector, pag	0	25. Was case referred to medical				26. Place of Dea	ith (Check only on			
f∨	Physician: rthis certificated ral director,	ToB	examiner? 1 — Yes 2 — Mo	Hospital: 1 Impatier	nt 2 ER/Out	patient 3 DOA	her: 4 Nursing H	ome 5 Reside			ify)
ion o	Attending Pt ir death. ector: After th by the funeral	atlon:	27. Manner of Death 1 Autural 5 Pending 2 Accident investigation		y 28b. T	ijury Wo	nyat nk?]Yes 2 □ No	28d. Describe ho	ow injury occ	curred	
Divis	tal or Atters as after de al Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	iry - At home, far :. (Specify)	m, street, factory, office		28f. Location (St City or Town	reet and Nu n, State)	mber or Rui	ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical			examination and	death occurred at the t for investigation, in my		rred at the time, d	ate and plac	e, and due	to the cause(s)
	With: To til comp	Σ	29b. Signature and title of certifier				se number		9d. Date sig		
			1652.	THU P.	2 ·	PES	-000	1	Novema	ER 15	, 2004
	5		30. Name and address of person who TEREMY M. HVFF.	D.D. SIN	eath (Item 23a) (IAI Hospi	Type, Print) m of Bn	AMORE				
×	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	m of Br					

PRIBLY FALOUD AS EDWIN HERMAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10: 35 PM 11 J. Johnson 1 06 07 /Medical 4c. County 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Genesis - Long Green altimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months 1**∑**M 2□ F MD 214.82.6118 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ems 23a or 28a-f shor r must be notified a Baltimore 1 X es 2 □ No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 2 may injury or other traumatic event, the Medical Examiner must be n once. Circle Apt. D USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 No Black þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Home Improvement Elementary/Secondary (0-12) arade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Man Brace Johnson, 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Circle Apt. D Balto. MD 21239 4916 Lachlan Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Bunal 2 ☐ Cremation 3 ☐Removal from State Mt. Zion Cemeteni 11.11.06 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Ander York Kond 21. Signature of Funeral Service Licensee Puneral Services Baltimore MD 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of) aspination Examiner reumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury .(or as a consequence of) Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last sequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) I Yes 2 □ No 9 ☐ Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Baltimore, Maryland 21215-0036

29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. License number カヨマアノナ 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

32 Registrar's Signati

State Registrar

Medical

within 24 hours at To the Funeral Completely filled i

Johnson, Cardyn

Registrar DHMH 17 Rev 1/2001

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State

SINAI GOSPITAL OF BALTIMOKE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

32. Registrar's Signature

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 0 0 6 36480 Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** TACK SIM 2006 6:37 a[™] Nov. 14 RUGGET /Medical 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Yrs. 87 11, 1919 Georgia Director 277-12-7330 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show the Medical Exactiner must be notified at 1K Yes 2 No Montgomery Silver Spring Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8201 16th Street #707 20910 USA death Funeral Iteme : 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ⊠Yes 2 No. If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 X Married 1940 - 1941 Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 X No Specify: δ 3 Widowed 4 Divorced Black. 'naturel' Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2 years Disabled Veteran US Military permit. Pages 1 and 2 should be filed v. Depertment of Health and Mental Hygie. Important: if Item 27 is marked other til eny injury or other treumatic event, IIIs once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Glenn Jackson Willie Cox 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) 8201 16th Street, #707 Silver Spring, Md. 20910 19a. Informant's Name/Relationship (Type, Print) June K. Jackson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico Nat'1 Cem. ! 11-22-2006 Triangle, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARTHERUS (LEMIT) C **Physician** HEART DISFASE. /Medical Due to (or as a consequence of): Examiner STA66 Roman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year detached for 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2∏No 1 Yes 2 X No 1 ☐ Yes : After this certifice e funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 XNatural 5 Pending investigation 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 48083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Ave. Takoma Park, MD. 20912 Irving Westney, MD 32. Aggistrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 7 2006 Registrar

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, aftending physician for use as the burial has il or Attending Physician: after death. Director: Atter this certifica funeral director,

Baltimore, Maryland 21215-0036

been signed by t should be detach filled in by within 24 hours at To the Funeral D

5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

29b. Signature and title of certifier

29c. License number 731,660 29d. Date signed (Month, Day, Year) 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WESTMINSTEIR MARYLAND STUMBER AVENUE I HOMAS GALUN III_MO 291 21155

State Registrar

31. Date filed (Month, Day, Year) 2006 1 NOV 7

32. Registrar's Signature

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and manner stated.

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		•	1 - For State Registrar	State of Ivial	iylanu / L	Certificate	of Dea	ith	illai i iy	Reg. No.	UUD	J	948
	表		Decedent's Name (First, Middle, Last,)				2	Date of De	eath Day	Year	3. Time	of Death
	Physici /Medic		Dietrich	Gina Jo	nes			^	Evem			6:38	PM
	Examir		4a. Facility Name (If not institution, give					tion of Death			inty of Death	ר	
			Sinai Hospital of	Baltimo				e City	-		NIA		
ı	Funeral Director		210-08-3230	7	(In yrs. last bin	hday) If Under 1 Y Months D	ays Ho		Month, Date of Bi	ay, Year)	9. Birth	nplace (Stat untry) MD	e or Foreign
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. fnside	City Limits
	Manyi f sho	ō	MD N/A		Balt	imore						1 ∑ Y	es 2 No
	28a	Director	10e. Street and Number			10f. Zip Co	de			10g. Citizen	of What Co	untry?	
	h with		2805 Oakley A	venue		2	21215			US	SA		
	deat	Funeral	11. Maritaf Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Decedent If Yes, specify	of Hispani Cuban, Me	c Origin? (Speci xican, Puerto Ri	fy Yes or No	0- 14. F	Race - Amer Black, White		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23s or 28s-f show other traumatic event, the Medical Exandrat must be inclined at	þ	1 Never Married 2 Married 3 Widowed 4XXPivorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:)	1 □ Yes 2√⊡		ecify:			city:	lack	
ဂ ဂ	72 ho natu	etec	15. Decedent's Edu (Specify only highest grad		16a.	Decedent's Usual O (Give kind of work of	one auring	most of working	7	16b. Kind o	f Business/l	ndustry	
7	filed within 72 Hygiene. other than "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+ N/A) N	`lite. DO NOT use r urse's Ass		nt		Vā	arious	5	
	filed w Hygier sther th		17. Father's Name (First, Middle, Last)	14/ 13	1			fother's Name (First, Middle				
and	Mental I	o Be	James Thomas	5				Elizabe	eth		Pe	eace	
Maryiand	should be and Mental te marked aumatic ev	၉	19a. Informant's Name/Relationship (T)	/pe, Print)		Mailing Address (Si							
	and 2 ealth a m 27 to		Elizabeth Spencer-	-mother	1	322 N. Sto	ockto	n St. Ba	altimo	re, MD	212	217	
ē,	tem Item		20a. Method of Disposition	2	20b. Place of cemeter	Disposition (Name of the or other	of r place)	Dat	te	20c. Locatio	on - City or 1	Town, State	
Ē	Pages nent of ant: # It ary or o		1 Donation 5 ☐ Other (Specify)			Memorial 1		11/18/	/2006	Randa	allsto	own	MD
Baltimore,	permit. Pages 1 Department of F Important: If Ite eny Injury or ot		21. Signature of Funeral Service Licens	999		22. Name and A							
n	#Q = ₽ 9		Bladys	Warre				th Avenu			, MD	2120	
			23a. Part1. Enter the disease, or comp. shock, or heart failure. List only o	lications that caused to ne cause on each line	he death. Do r),	not enter the mode o	dying, suc	h as cardiac or r	respiratory a	arrest,		Approxin fnterval E Onset ar	Between
	Physician		Immediate Cause (Finaf disease or condition resulting in death)	a Sepsi	5							1 da	4
ı	/Medical Examiner		resulting in dealth)	Due to (or as a	consequence	of):							0
		<u>~</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	of):							
/	uted 1	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
<u>-</u>	execting and and ital-tra	Exa	resulting in death) Last	Due to (or as a	consequence	of):							
68/60,	rificate be executed ng physician and as the burial-transit	edical	(d									
	ntifica ing ph	Med	IF FEMALE:										
C. Box	es that the death cert igned by the attendin be detached for use	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcome o 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death	3 ☐Ectopic pregr 5 ☐ Other (special				1	Date of deline Month	very Day	Year
J.	The law requires that the ste has been signed by th bage 2 should be detache	P.	Part II. Other significant conditions co	ntributing to death but	not resulting in	the underlying caus	e given in f	Part I.	23e. Did	tobacco use c	ontribute to	the cause of	of death?
ds	uires sign								1 🗆	Yes 2 Div	3 ☐ Pro	obably 4	∐Unknown
Vital Records,	w require s been si should b	Completed							24a. Was		b. Were au	topsy findin	gs available
T T	nystcian: The fav nis certificate has I director, page 2	E O							auto perf	ormed?	death?	2 No	or cause or
Itai		8	25. Was case referred to medicaf				26. 1	Place of Death (
>	nysici nis ce direc	To B	examiner? 1 🗆 Yes 2 🕩 No	Hospital: 1 Impation	t 2 ER/Ou	tpatient 3 DOA	Other: 4[Nursing Home	5 ☐ Res	idence 6 🗆	Other (Spec	cify)	
Division of	ng Pł		27. Manner of Death 1 ☑ Naturaf 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. 1		Injury at Work?		d. Describe	how injury oc	curred		
S S	tendi leath. tor: A	catl	2 Accident investigation 3 Suicide 6 Could not be			М	1 Tes		f Location	(Street and Nu	mbas as Ou	ral Pauta M	· mhor
\leq	or Attendin after death. Director: Af in by the fur	Certification:	4 Homicide determined	building, etc.	y - At nome, ra (Specify)	rm, street, factory, o	TICE	20		own, State)	inder or Au	ITAI MUUITE IV	umoer,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,	edical Ce	(Check only 2 Madical Exam	rsician: To the best of iner: On the basis of e	examination an	d/or investigation, in	my opinion	, death occurred	at the time				e(s)
	To the I within 2 To the I complet	Med	one) 29b. Signature and title of optifier	and manner state	ed.	29c. L	cense num	ber		29d. Date sig	gned (Monti	n, Day, Year	-)
	7 ¥ € 8		9 69	2	m	DK	25-0	00		Novemi			
	4		30. Name and address of person who c	ompleted cause of de	ath (ftem 23a)	(Type, Print)							
			Elouna Lin	, MO SI	non ito	spital 1	Ba	Uhmer	e.				
2	St	ite	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	29c. L (Type, Print) Spital (
0	Regist	rar	NOV 1 7 2	606	والمحالي المصاف	1 Town							

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6

36482

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8:25 P M Johnston November 11, 2006 Richard 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rockville Montgomery Potomac Valley Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Pennsylvania 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days 181-16-6540 86 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Connellsville Pennsylvania Favette 1 VYes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 15425 United States 211 Lincoln Avenue 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married WWII White 1 ☐ Yes 2X No Specify 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Pennsylvania Mathematician 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Agnes Gregg Richard Johnston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2210 Coppersmith Square, Reston, Virginia 20191 Richard Neville Johnston /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 Burial 2 □ Cremation 3 ☐Removal from State Allegheny Cemetery Pittsburgh, Pennsylvania 4 □ Donation 5 □ Other (Specify) 2006 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 23a. Part1. Eng. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause—each line. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Immediate Cause (Final disease or condition resulting in death) ATTOSHEC Due to (or as a consequence of) F131714710 VENTRICULKE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown

Physician /Medical Examiner

burial-tra

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Completed

Be

Medical Certification: To

or Attending Physician: The law requires that the death certificate be executed

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After 1

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filled in

hours after death uneral Director:

within 24 hours a Hospital

P.O. Box 68760,

Division or Vital Records,

Physician

/Medical

Examiner

Funeral Director

Be Completed by

ဥ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any lijury or other traumatic excessions.

Examiner

Physician/Medical IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🔲 Inpatient

24a. Was an

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

autonsy performed 1 Yes 2 ☑ 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 21⁄€ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 ☐ Suicide

28a. Date of Injury (Month, Day Year) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

Other: 412 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

29a. Certifier (Check only one)

4 Homicide

1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of dertifier

40051280

29c. License number

29d. Date signed (Month, Day, Year)

11-13-06

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dadgar, DO, 9715 Medical Center Drive, #201, Rockville, Maryland 20850 Anushiravan 31. Date filed (Month, Day, Year)

20 State Registrar

32. Registrar's Signature 2004



		For State	state of Ma	ryland / Dep	artment of Hertificate of L	ealth an	nd Mental Hy	giene _{Beg. No.} 20	06	36484
		Registrar 1. Decedent's Name (First, Middle, Last)			Timoato o. L		2. Date of De	ath		3. Time of Death
Physic	ian	Mary Josephi	ne Cox	Jansons			Novembe	er 10, 2	006	12:31 P ^M
/Med		4a. Facility Name (If not institution, give stre		o tilibolib	4b. City, Town, or	Location of I		4c. County		
Exami	ner	Wilson Health Care			Gaithe			Montg	omer	·V
	S. Carrier	5. Social Security Number 6. Sex		(In yrs. last birthda)	If Under 1 Year	If Under 24			9. Birth	nplace (State or Foreign untry)
Funeral Director				90 Yrs.	Months Days	Hours	November	12, 1915		souri
	C.	Usual Residence of Decedent								40d Incide City Limits
yland		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits 1 ☐ Yes 2 X No
Mar.	to	Maryland Montgomer	y	Bethe	sda					
h the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of		
"neture", or Items 23a or 28a-f show	Funeral Director	5512 Pembroke Terr	ace		208			United		
deet	ner	11. Marital Status	Was Decedent E Armed Forces?	Ever in U.S. 13	 Was Decedent of H if Yes, specify Cuba 	ispanic Origi ın, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	14. Ra	ce - Ame ck, White	ncan Indian, a, etc.
hours after turel; or ite	F	1 Never Married 2 Married	1 ☐ Yes 2 X N If Yes, Give	lo	1 ☐ Yes 2 🕅 No	Specify:		Specia	y: W	Thite
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72 hours af "neturel", or	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	(Gir	edent's Usual Occup we kind of work done of DO NOT use retired	during most o	of working	100.14110 01 2	351110041	,
within 72 ene. than "net na Medic	μ	Elementary/Secondary (0-12)	College (1-4or 5	4)	iness Exec			Self H	Emp1c	oyed
D D		17. Father's Name (First, Middle, Last)					s Name (First, Middle	, Maiden Suma	тө)	
	Be	Norris Cox				Ruth	C. Love			
2 should be and Mental is marked summittees	ြို	19a. Informant's Name/Relationship (Type	Print)	19b. Ma	iling Address (Street	and Number	or Rural Route Numb	oer, City or Town	, State, 2	Zip Code) 29401
re, Maryic s 1 and 2 should f Health and Mer item 27 is marks other trsumatic		Marion J. Schutt /					et, Charle			
e, N 1 and 1 and Health em 27 ther tr		20a. Method of Disposition	544811001		position (Name of rematory or other place		lov. Date 2,	20c. Location		
Pages nent of ant: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State		y Crematorium		2006	Bethes	da, I	Maryland
it. Partiment		21. Signature of Funeral Service Licensee	/				Tuneral Home			
Baltimore, permit. Pages 1 a Department of Hee Important: if item eny injury or othe		Macletta Romas	M M	01305	Robert A. Pun OO West Mont	mphrey i comerv	Avenue, Rock	ville, Ma	e, inc	d 20850–2805
		23a. Part1/Enter the disease, or complica	ations that caused	the death. Do not	enter the mode of dyin	ng, such as c	ardiac or respiratory	arrest,		Approximate Interval Between
		shock or heart failure. List only one Immediate Cause (Final	cause on each lin	10.		1	,			Onset and Death
Physician /Medica		disease or condition resulting in death)	Due to for as	a consequence of:	luret.					
Examine			Asli	Lane	edde	me	ntea			
	e L	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):						
insit	n n	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
1760, te be executed systicien and ne burial-transit	Examiner	resulting in death) Last	Due to (or as	a consequence of):						
te be ex ysicien he burial	cail									
Box 68 and certificate attending phy for use as the										
OX th cert ending	2	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome	of pregnancy 2 Petal death	3 ☐Ectopic pregnanc	:v			ate of de	livery Day Year
G for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant a		5 Other (specify)				TOTAL	Day 100
P.O. By that the death ed by the atte	hvs	9 Unknown							-1-1-1-1	to the cause of death?
Records, P.O. Box 68 The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as if	Completed by Physician/Med	Part II. Other significant conditions cont		_				_/		robably 4 Unknown
rds quire an sig	ed	Pladucas			yperts.	nece	se			
Records, he law requires t e has been signe age 2 should be	olet	Chronicabet	water	refuln	may	Lexe	eee 24a. Wa	topsy	prior to	utopsy findings available completion of cause of
The lay	200	Leeur, tu	uxacı	, Frank.	rifection	n 42	cencia 1 Yes	formed? 2 No	death? 1 ☐ Ye	s 2 No
	4	25. Was case referred to medical	- 1		0	26. Place	of Death (Check only	y one)		
	ToB		ospital: 1 🗌 Inpati	ent 2 ER/Outpa	itient 3 DOA Ct	then 4 Nu	rsing Home 5 🗆 Re			ecify)
n of g Phys gerthis neral di	5	27. Manner of Death	28a. Date of Inju (Month, Da	ury 28b. Tim ay Year) Inju	ry Wo	ork?		e how injury occ	urred	
Division of Attending after death. Director: After din by the fune	140	1 Patural 5 Pending 2 Accident investigation			M 10	Yes 2 1				2 / 0 - 1 1 1
ViS Atte Br de recto	Certification.	3 Suicide 6 Could not be determined	28e. Place of In building, e	ijury - At home, farm tc. <i>(Specify)</i>	, street, factory, office)	28f. Location City or 1	(Street and Nui Town, State)	noer or r	Rural Route Number,
Div tel or rs afte el Dir ed in	9							42 -4		
Division o ne Hospitel or Attending Ph n 24 hours after death. ne Funerel Director: After the pletely filled in by the funeral	icologi		ician: To the best er: On the basis	t of my knowledge, of of examination and/o	leath occurred at the to investigation, in my	time, date an opinion, dea	d place, and due to the th occurred at the tim	ne cause(s) and e, date and plac	manner a e, and di	is stated. Le to the cause(s)
Divi	ipal		and manner s	tated.		nse number				nth, Day, Year)
To To	2	29b. Signature and title of certifier	1	. /			1	-		
		1 N. Ribert.	June	heart	ns i		7	1	ine.	010/100
2	0	30. Name and address of person who co			(pe, Print) 26	Rec	ssell	quen	20	210,2006
.,		W. Rose Stad (About Day York)		LL WW	Cla	un	review (, and		, ,
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Heg	istra	NIJV I (LUVU P	- colored a series	March 1					

Jefferson, Joy 06-08566

Please Type or Print in Black Indelible Ink **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2006 36485 1- For State Certificate of Death Reg No Registrar 2. Date of Death Physician/ Month Day November 10, 2006 1232 hrs **Medical Examiner** Joy T. Carter 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 2306 East Oliver Street Baltimore N/A Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or **Funeral** Months Days Hours Min Foreign Director 217-90-7004 33 1973 Country) 1 M 2 XF 4 Yrs MD Usual Residence of Decedent 10a State Oc. City, Town or Location 10d. Inside City Limits any X Yes 2 No MD N/A 28a-f show Baltimore notified at once. hours after death with the Maryland Director 10e Street and Number 10f, Zip Code 10g, Citizen of What Country' 2310 Riggs Avenue Apt. 21216 USA 238 Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Race - American Indian, Black, Armed Forces? Never Married 2 X Married White, etc. Yes 2 X No Widowed Divorced f Yes, Give Year Yes 2X No specify: Specify: Black þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ I and 2 should be filed within 72 | Health and Mental Hygiene. item 27 is marked other than ' traumatic event, the Medical MD 21215-0036 N/A Unemployed N/A 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Joseph Jefferson Faith <u>Johns</u> 19a Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faith Faire-sister 2310 Riggs Avenue Apt. 3B Baltimore, MD 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Date 20c. Location - City or Town, State Baltimore, crematory or other place) tant: If it Pages I X Burial 2 Cremation 3 Removal from State King Memorial Park 11/17/2006 Donation 5 Other Specify. Randallstown MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 1101 E. North Avenue Baltimore, MD 21202 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Mixed Alcohol and Irux (heroin and Cocaine) intoxication Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED X AMENDED attending physician or use as the burial perME, g861 11/30/06 TT #23a,27,28a-f, Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? No ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be examiner? Other₄ Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 ✔ Other Scene this FR/Outpatient 3 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Natural e Funeral Director: A etely filled in by the fu Yes 2 No 5 Pending Fnd 11/10/2006 Fnd 12:25 pm unknown 2 Accident Investigation 28f Location (Street and Number or Rural Route Number, City or Town, State) 2306 E. Oliver Street Baltimore. MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide determined (Specify) Baltimore. Homicide vacant house 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. (Check only Medical To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 11, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD 31. Date filed (Month, Day, Year) State

Registrar

2006

NOV 1

DHMH 17 Rev 1/2001

06-08440

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Masako Katahira Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 6, 2006 1736 hrs Masako Katahira Medical Examiner MASEKO KESERIPA 4b. City, Town, or Location of Death 4c County of Death Howard Ellicott City 9105 Whitehall Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number 6. Sex 7 Age (In yrs last birthday) **Funeral** Months Days Hours Mir Director Country) 4/4/1949 1 M 2 F Japan 3789 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County any Ellicott City 1 Yes 2 X No s 23a or 28a-f show e notified at once. MD Howard Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene Director 10f. Zip Code 10g. Citizen of What Country 10e Street and Number 9105 White Hall Rd. 21042 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 8lack, Funeral 11. Marital Status 12. Was Decedent Ever in U.S or items Armed Forces? 1 Never Married 2 X Married Yes Asian Yes 2 No specify f Yes, Give Year Specify Widowed Divorced nt of Health and Mental Hygiene
4: If item 27 is marked other than "natural",
other traumatic event, the Medical Examiner <u>م</u> r Dates: 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Flementary/Secondary (0-12) Baltimore, MD 21215-0036 Japanese Interpreter Own Business 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jyotaro Takashima Kazuko Takashima 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 9105 Rd. El<u>licott City</u>, Robert Reed Husband White Hall ΜD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State permit Pages Department o 11/13/06 A I ICo. Crematory Sykesville, Donation 5 Other Specify. Home, P.A MD 21043 22. Name and Address of Facility 5 1 a C K Funeral Pike E.C. Signature of Fuperal Service Licens 3871 01d Columbia Pike Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician **8etween Onset and** failure. List only one cause on each line. Death /Medical a. Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical x AMENDED 1 per me g861 11-17-06 vt UNPENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ò Completed 24a Was an 24b. Were autopsy findings available page 2 should prior to completion of cause of autopsy death? certificate has performed? Yes 2 V No Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Nursing Home 5 Residence 6 Other Scene DOA Inpatient ER/Outpatient 3 1 🗸 Yes After this ٩ funeral 28a. Date of Injury FOUND: Day, Year) 28c. Injury at Work? 28d Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Subject hanged self **FOUND** 1 Yes 2 V No Natural Pending Nov 6, 2006 1730 hrs To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 9105 Whitehall Road, Ellicott City, MD determined (Specify) Single Family Home Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d Date signed (Month, Day, Year) 29c. License number 296. Signa November 7, 2006 O.C.M.E. of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 2006

DHMH 17 Rev 1/2001 OCME 2006

Registrar

		•	For State Registrar	State of Marylan		tificate of			eg. No.	10	36488
			Decedent's Name (First, Middle, Last	1)				2. Date of Deat Month	lh .	Vane	3. Time of Death
	Physicia /Medic		Elizabeth Shanno	n Lovelace				Novembe	er 14, 2	2006	12:52 P™
	Examin	_	4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of		
			Franklin Square H			Rosedal	_		Balti		
	Funeral Director		224-22-3974	7. Age (In yrs. 83	last birthday) Yrs.	If Under 1 Year Months Days	ff Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 25	Year)	Coun	lace (State or Foreign try) inia
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Mac	Director	Maryland Baltimor	e Mic	ddle Ri	ver					1 ☐ Yes XXNo
	or 28	Olre	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Coun	try?
	ath w	- a	1202 Tupelo Place			21220			U.S.A.		
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-f show appringing or other traumatic event, the Marical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of F f Yes, specify Cubi 1 ☐ Yes 2☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes of No- Rican, etc.)		c, White,	an Indian, etc. ite
Q Q	72 ho	Completed	15. Decedent's Ed		16a. Deced	dent's Usual Occup	pation during most of work	ina	16b. Kind of Bus	siness/Inc	lustry
2	thin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	during most of work d)	9			
7	ygien ygien yer th	S	12		Seamst	ress	18. Mother's Nam	- /First Middle I	Clothin		
and	be fill H by otland	Be	17. Father's Name (First, Middle, Last) Jason Osborne Bur	nett			Emma Ire			9)	
چ	d Mer d Mer narke	2	19a. Informant's Name/Relationship (7		19h Mailin	a Address /Street	and Number or Rur			State Zin	Code)
N N	id 2 slith and 27 is 1		Rebecca Lovelace				lace, Bal				
စ်	Heal Heal tem 2		20a. Method of Disposition			sition (Name of natory or other pla			20c. Location - 0		
OL	Pages ent of tr. if i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	memovar irom State			ard.Nov.1	8.2006 F	Raltimor	e. M	arvland
Ħ	mit. Foortan		21. Signature of Funeral Service Licent				uzdzinski				
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	Physician /Medical Examiner	Examiner	23a. Since Enter the disease, or complete, or heart failure. List only of the complete the compl	b	uence of):	Myse		l In	farct	in	Approximate Interval Between Onset and Death
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Box 68	eath certifica attending ph for use as th	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		7c			23d. Date	of delive	iry
P.O. B	ires that the death cer signed by the attendin d be detached for use	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1□Live birth 2□Feta 4□Pregnant at time of c 9□Unknown		Ectopic pregnanc Other (specify)	y 		Mon	ith	Day Year
	w requires that been signed b should be deta	ed by PI	Part II. Dther significant conditions of	entributing to death but not res	ufting in the u	nderlying cause giv	ven in Part I.	23e. Did tol			ne cause of death? ably 4 □Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: Atter this certificete hes been signed by the attendincompletely filled in by the funeral director, page 2 should be detached for use	Completed						24a. Was a autops perform	med? d	rior to cor eath?	psy findings available inpletion of cause of
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hamital.		0.0	26. Place of Deal	h (Check only on	(6)		
of	Physi this o	ဥ	1 ☐ Yes 2 🔀 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatien	IL 3 DOA		ome 5 Reside			")
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_	Hospita 24 hours Funerel stely filled	Medical C		ysicien: To the best of my kno niner: On the basis of examina and manner stated.							
	To the	₩.	29b. Signature and title of certifier	MI	1	29c. Licens	se number	2	9d. Date signed	(Month,	Day, Year)
	~		1 (10)	of con	relly	my 4	130133		11/1	6/	06
	10		30. Name and address of person who o	completed cause of death (Iter	m 23a) (Type.	Print)					
	10		JOSEPH GNNE	114, mp. 100	BEAC	ON ROAL	BALTE	morte, N	10. 21	22	0
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature A)30155 BAUTE	,			

06-08637 Alma Leyfield

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar		ificate of Death	Re	eg. No.
Physician/ 1. Decedent's Name (First, Mic	ddle,Last)	LAYFIELD	2. Date of Deat Month November	
Medical Examiner ATMA 4a. Facility Name (if not institute)	tion, give street and number)		Location of Death	4c. County of Death
4215 Bayonne Aven		Baltimore		NA
Funeral Director 244 03 1196	6. Sex 7. Age (In yrs. las	92 Yrs. If Under 1 Yea Months Day		/1913 9. Birthplace (State or Foreign Country) NC
Usual Residence of Decedent 10a. State 10b. Count MD BALT 10c. Street and Number		fown or Location SEDALE	The state of the s	10d. Inside City Limits 1 Yes 2 X No
in the Maryland 10e Street and Number 10e St	AD.	10f. Zip Çode 21237	10	Og. Citizen of What Country? USA
to Company and Street and Number 100. Street	1 Yes 2 A No Divorced If Yes, Give Year		spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.) specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Some and particular and p	pecify only highest grade completed)	16a. Decedent's Usual Occupa during most of working life		16b. Kind of Business/Industry
12 17. Father's Name (First, Middle 17. Father's Name (First, Midd	0	SEAMSTRESS	19 Mathada Nama /First Middle B	GARMENT (Sumana)
	CRU		18.Mother's Name (First, Middle, M CHRISTINE	BLACKWELLER
				ber, City or Town, State, Zip Code)
2 G g g g g g g g g g g g g g g g g g g		lace of Disposition (Name of ce		MD 21237 20c. Location - City or Town, State
20a. Method of Disposition 1	Specify: GAR	RDENS OF FAITH 22. Name and Address		BALTIMORE, MD
De minimo De minimo de min	S Elicensee	1211 CHESA	CVACH/RUSI	EDALE FUNERAL HOME LE, MD 21237
failure. List only one cau Medical Immediate Cause (Final diseau	se a. Atherosclerotic Cardiova		such as cardiac or respiratory arre	Approximate Interval Between Onset and Death
or condition resulting in death	Due to (or as a consequence of).b.	:		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau. (Disease or injury that initiated events resulting in death) Las		:		
para la la la la la la la la la la la la la		:	•	
Medical an Opposition and Delivation and Delivation and Delivation and Delivation of D	AMENDED			
23b. Was decedent pregnant in past 12 months?	1 the 23c. If yes, outcome of pregnation the 23c. If yes, outcome of yes, out	2 Fetal death 3	Ectopic pregnancy	23d. Date of delivery Month Day Year
Part II. Other significant con	ditions contributing to death but not res	sulting in the underlying cause (given in Part I. 23e. Did to	bacco use contribute to the cause of death?
or or or or or or or or or or or or or o			1 Yes 24a. Was a	2 No 3 Probably 4 Unknown
Records, The law requires froate has been signed. Page 2 should be Completed			autops perfor	sy prior to completion of cause of
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tending of the feet of the fee	(Month, Day, Year) ending		res 2 No	ow injury occurred
Division of Vital Records, spiral or Attending Physician: The law requiremental Director. After this certificate has been similarly the funeral director, page 2 should be a completed or should be a completed or should be a completed or certification: The law requiremental director, page 2 should be a completed or certification: The law requiremental properties of the complete or certification o	vestigation 28e. Place of Injury - At hor etermined (Specify)	me, farm, street, factory, office b	uilding, etc. 28f. Location (S or Town, St	treet and Number or Rural Route Number, City ate)
Division To the Hospital or Attend To the Funeral Director: To the Funeral Director: Completely Library Confidence To the Funeral Director: Completely Library Confidence A Homicide To the Funeral Director: Completely Library Confidence To the Funeral Director: Complet	Physician: To the best of my knowledge xaminer:On the basis of examination and and manner stated.			
29b. Signature and title of cert		29c. Licens		29d. Date signed (Month, Day, Year)
Theodore	M. King JR. 12	0.C.	VI.⊏.	November 13, 2006
90 Mana	on who completed solved of death (Il f	73a\		
30. Name and address of pers Theodore M. King,	on who completed cause of death (Ifem 2 Ir., MD. Assistant Medical Ex		reet, Baltimore, MD 21201	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John Girard Lacey, Jr. NOV 40 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown Birthplace (State or Foreign Country)
 M D 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7 / 6 / 1 9 2 9 **Funeral** Days 1 M 2□F 229.24.5562 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 'natural", or items 23a or 28a-f shov dkal Examiner must be notified at 1 □Yes 2 No MD Director Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 116 Sunflower Drive 21740 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales & Marketing Exec. Communications 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Girard Lacey Elizabeth Agnes Kelly ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 l Mrs. Shelia Ellis daughter 8605 Neck Rd. Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Lorraine Park 11/17/06 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Slack Funeral Home, 21. Signature of Funeral Service Dicensee 3871 Old Columbia Pike, Ellicott City21043 23a. Part1. Enter the disease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final QUELOVOVASUILAR Physician disease or condition resulting in death) udays /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to minerials cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a nonsequence or, Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide file Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D28365 11-12-06 368 mill Stral-Hagerstown 14/02/740 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

			For Stete Registrer	State of Ma	-	partment o		and Mental Hy	ygiene Reg. No. 0 0	36491			
	Dhysisi		1. Decedent's Name (First, Middle, La	st)				2. Date of D Month		3. Time of Death			
	Physici /Medio		CHARLES		LE	WIS		Novem	mber 11 2006 4 AM				
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)			m, or Location o		4c. County of	of Death			
			JOHNS HOPKINS BAY				BAUTINGER 2			0.000			
П	Funeral		5. Social Security Number 6. S	EDM OF	e (In yrs. last birthd GO Yrs	Months Da	ays Hours	Min. (Month, D	lay, Year)	Birthplace (State or Foreign Country)			
	Director	ļ	Usual Residence of Decedent		68 Yrs			02	20 38	NC			
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	r 28g	rec	10e. Street and Number			10f. Zip Cod	de		10g. Citizen of W	/hat Country?			
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	item 27		20a. Method of Disposition	-DISCEL		sposition (Name or rematory or other		Date	-	City or Town, State			
altimore,	00		1 ☐ Burial 2√☐ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Special	Removal from State	1		1	11/16/0					
₹	permit. Page Department Important: if eny injury o		21. Si mature of Funeral Service Lice	£	Metro	22. Name and A	ry Inc	11/16/0	b Balt.	imore, Md			
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			23a. Part 1. Forter the disease, or com	plications that caused						Approximate			
			shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	10.	1				Interval Between Onset and Death			
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ta	ien: ortifica ctor,	Bec	25. Was case referred to medical examiner?				26. Place	of Death (Check only	one)				
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∑	il or Attenater deat Director:	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury · At home, farm, c. (Specify)	street, factory, off	ice	28f. Location City or To	(Street and Number own, State)	or or Rural Route Number,			
Ω	urs al				ME CGA					BALTIMILE, MD			
	Hospital 24 hours a Funerel letely filled	edical	(Check only 2 Medical Exer		examination and/or	eath occurred at the investigation, in r	e time, date and ny opinion, deatl	d place, and due to the h occurred at the time	cause(s) and man date and place, ar	nner as stated. nd due to the cause(s)			
	To the Hospital within 24 hours a To the Funerel completely filled	Med	one) 29b. Signature and title of certifier	and manner sta	nted.	29n Lin	ense number		29d Date signed	(Month, Day, Year)			
-	N N N		200. Signature and title of certifiel						3				
	\cap		for the		e Physicia		000		11-15-	2006			
	0		30. Name and address of person who				^ +	2		200			
~			31. Date filed (Month, Day, Year)	32 Remiter	ar's Signature	- Juite 6	~(00)	saltimore,	MD 2/3	287			
	Sta Registr	_	NOV 1 7	1830 E. Ma 32. Registra 2006	was the	A STATE OF							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Reg. No. U Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 928 Physician) cloris 2006 Magwood 4a. Facility Name (Proof institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner pilare Bachman Hal himore HUS Cin 0 naci If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F 247-48-467 Usual Residence of Decedent Yrs. Director avolin 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural", or iteme 23a or 28a-1 show any injury or other traumatic event, it a Medical Exactlinat must be notified at once. Md 1 Yes 2 □ No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 5 A 14. Race - American Indian, Black, White, etc. AVe 2807 arrison Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12+2 nvironental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Purdy Washington

19a. Informant's Name/Relationship (Type, Print) Daughter /homas CUNICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Park Magwood-Stovall 1817 trancella Baltimore Ave Md 21217 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 11/17/06 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Md. Woodlawn Cemetery 22. Name and Address of Facility Charman - Harris Funeral Home 21. Signature of Funeral Service Licensee Ad Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PSIS Physician Se 7 days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner buriai-transit i or Attending Physicien: The law requires that the death certificate be executed end Due to (or as a consequence of) Box 68760, physicien Be Completed by Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ITEL autopsy performed? TV Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident the 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide the Hospitei 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Entmany Christina (31. Date filed (Month, Day, Year) NOV 1 7

DHMH 17 Rev 1/2001

State

Registrar

32. Fingistrar's Signature

2006

			1 - For Amend Item 2 Registrar	.3a per di	.,G861,L1	/17/06dhb	Death	Reg	2000 .No.	36493		
E.	Physici		Decedent's Name (First, Middle, Last) RUTH	EPST	IEN	MILLER	}	2. Date of Death Month NOVEMBER	Day Year 13, 2006	3. Time of Death 5:17 A M		
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death		4c. County of Death			
		re ^e	GREATER BALTIMOR 5. Social Security Number 6. Sex		CENTER (In yrs. last birthday)	TOV	ISON If Under 24 Hrs.	10.5-1-16:4	BALT:			
29	Funeral Director		138-16-9354	M 21X F	91 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y) 11/26/1	914 9. Birth	nplace (State or Foreign untry) NJ		
	land ow		Usual Residence of Decedent 10a. State 10b. County			10d. Inside City Limits						
	Mary e-f sh	tor	MD N,	/A	BALT	IMORE				1 X Yes 2 □ No		
	or 28e	Oirec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	intry?		
	s 23a	eral	2708 JEREMY COURT				21209		USA			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Examinar is used be rightlist at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N N If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	spanic Origin? (S n, Mexican, Puert Specify:	14. Race - Amer Black, White Specify:				
5-0	"natu	Completed	15. Decedent's Educ (Specify only highest grade			dent's Usual Occup- kind of work done	luring most of wor	king 16	b. Kind of Business/li	ndustry		
72	within ene. then be Me	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	+)4 FMP	DO NOT use retired LOYMENT C	•	NI	EW JERSEY	STATE		
פ	be filed ital Hygid other event, II	Be C	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma		OTATE		
Maryland	should by	ToE	ISRAEL		EPST		FANNI			BARNHART		
	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship (Type BERT MILLER / SON	oe, Print)					ity or Town, State, Zi MD 21215			
ore,	Pages 1 and of Heisont: If Item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	1	natory or other plac	'		c. Location - City or T			
Baltimore,	permit. Pa Departmen Importent: any injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			MON CEMET Name and Address	a of Coults.		_IFTON, NJ			
ä	Depar Impo any ir		Keet /c	Two			ERSTOWN	ROAD - PI	N & BROS., KESVILLE,			
÷.	Dharaisis.		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line	the death. Do not ent	er the mode of dyin		or respiratory arrest	•	Approximate Interval Between Onset and Death		
帝.	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a	consequence of):	arm e						
	Cxammer	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):		Uremi	a				
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
68760,	ificate be executed g physicien and as the burial-transit	edical E	L _d	Due to (or as a	consequence of):							
-	ng phy	Medi	IF FEMALE:									
.O. Box	The law requires thet the death certificate has been signed by the attending lage 2 should be detached for use as	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	it 12 months? 4 Pregnant at time of death 5 Other (specify)								
٩.	res thet the de signed by the a be detached f	y Ph	Part II. Other significant conditions cont	tributing to death bu	t not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	co use contribute to t	he cause of death?		
Sign	w require been sig should b	ted !	Peritonitis, Ren	nal failu	re			1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Unknown		
al Reco	: The law or cate has be page 2 sh	Comple						24a. Was an autopsy performed 1 Yes 2	prior to co	opsy findings available ompletion of cause of		
<u>=====================================</u>	sician	Be C	25. Was case referred to medical examiner? 1 □ Yes 2 No	ospital:		Othe	_	th Check only one				
_	> 00	٩	27. Manger of Death	1 Sonpatien		1 3L DOA	e 6 Other (Special	fy)				
o uo	nding Ph ath. r: After thi e funeral		1 ANatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) Injury		? ′es 2 □ No					
Division of Vital Records,	Itel or Attending Physician: The Is after death. re Director: After this certificate ha led in by the funeral director, page	Certification:	1 Natural 5 Pending		ry - At home, farm, stre	M 1 🗆 Y		281. Location (Stree City or Town, S	t and Number or Run late)	al Route Number,		
Division	Hospitel 4 hours a Funerel (ely filled	Certification:	1 Alatural 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, stre (Specify) f my knowledge, death examination and/or inv	M 1 1	e date and place	City or Town, S	(ate)	stated		
Division	To the Hospitel or Attending Phi within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral		1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Examin	28e. Place of Injurbuilding, etc.	ry - At home, farm, stre (Specify) f my knowledge, death examination and/or inv	M 1 1	e, date and place, inion, death occur	and due to the caus	(ate)	stated. o the cause(s)		
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			1 - For State Registrar	State of Mar		partment of Hertificate of L		ental Hygiei		36494	
	Physici	20	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death	
4	/Medic		LOUDELLE MOO					NOVEMBER			
	Examin	er	4a Facility Name (If not institution, give RON SECOURS HOS ROOD W. BALTIMO	re stree		BALT	Location of Death		4c. County of Death BALT / Ho		
l.	Funeral Director		5. Social Security Number 6. Se 214 - 88 -8332	7. Age (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye SEPTEMBER	ari (rthplace (State or Foreign ountry)	
	land w		10a. State 10b. County	1	Oc. City, Town or	Location				10d. tnside City Limits	
	Marylan n-f ahow ilied at	tor	MD N/A		Baut	more				1 Acres 2 No	
	with the 3a or 28a	Funeral Director	10e. Street and Number 831 N. Fulton	Street		10f. Zip Code	216	10g.	Citizen of What C	ountry?	
25	s I and 2 should be filed within 72 hours efter death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "naturel", or Itams 23a or 28a-f ahow other traumatic avent, Ita Medical Evantrar must be invitted at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	er in U.S.	B. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🗷 No	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	ocify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: 2		
5	72 hou		15. Decedent's Edu (Specify only highest grad	cation	16a. Dec	edent's Usual Occupa re kind of work done of DO NOT use retired	ation	16b	. Kind of Busines:	/Industry	
717	filed within 72 Hygiene. other then "nei ent, If a Medici	Completed	Elementary/Secondary (0-12)	Pomes	tic						
	ould be filed with Mental Hygiene arked other tha atic avent, if a la	To Be (17. Father's Name (First, Middle, Last) Honny Redfern	den Sumame)							
Mary	1 and 2 should Health and Men tam 27 is marke other traumatic		Melvin L. Hines	Son	19b. Ma	iling Address (Street a	A !		ty or Town, State,	Zip Code) 21229	
ני בו	Pages 1 and Ment of He Int: If Itam		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	Removal from State	20b. Place of Dis cemetery, co	position (Name of rematory or other place Cemetery	9)	ate 20c	. Location - City o		
-	permit. Pages Depertment of h Important: if its any injury or of once.		21. Signature of Funeral Services icens	il L. Mo	0944	22 Name and Ad Vaugun (4905 York					
b .	al		23a. Part1. Enter the disease, or comb shock, or hear thilure. List only of Immediate Cause (Final		e death. Do not e	inter the mode of dyin	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)		consequence of):	INTESTI	VAL BLE	ED			
	Examiner	L	Sequentially list conditions,	HEMOR Due to (or as a		E					
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5	execu an and rial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a c	consequence of):			<u> </u>			
	cate be executed physician and the burial-transit	dical		d							
Š .		1 OU 1	IF FEMALE:	3c. If yes, outcome of	Drago 2004						
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death, within 24 hours after death. To the Furnactal Director After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown	23d. Date of delivery Month Day Year							
U3, L	luires thet n signed b uld be deta	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did tobacc		o the cause of death?	
200	he law rec s hes bee ge 2 shou	Completed						24a. Was an autopsy performed	2 death?	utopsy findings available completion of cause of	
<u> </u>	an: T tificet tor. pe	0	25. Was case referred to medical				26. Place of Death	(Check only one)	No 1 □ Ye	s 2/21No	
>	hysici nis ce I direc	To B	examiner? 1 □ Yes 2★ No	lospital: 1 ☐ Inpatient	EP/Outpat	ent 3 DOA Othe	er: 4 🗌 Nursing Hor	ne 5 Residence	6 □Other (Sp	acify)	
	anding Pi ath. or: After the		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Time (ear) Injury	Worl	y at ⟨? Yes 2 □ No	28d. Describe how in	njury occurred		
	tal or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury building, etc.	- At home, farm, (Specify)	street, factory, office	-	28f. Location (Street City or Town, St	and Number or F ate)	tural Route Number,	
	the Hospi in 24 hou the Funer pletely fill	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	sician: To the best of ner: On the basis of ea and manner state				and due to the cause ad at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)	
	Vith Com	Σ	29b. Signature and title of certifier			29c. License			Date signed (Mor		
			Pologei	MD			59290	Nov	EMBEL	14,2006	
	3		30. Name and address of person who'd BETTINA ADJEI			e, Print) IMORE 5	TREET	BALTINOR	E MARY	14,2006 LAND 21223	
į	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 7 201	32. Alegistrar's	s Signature	Sach i	•				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene) 36495 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Vear 6:35 A. Adele M. Mihm November 16, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 4356 Back Woods Road Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖫 F Yrs Director 212-46-1774 59 June 26,1947 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 23a or 28a-f ehow the Mudical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4356 Back Woods Road 21158 USA filed within 72 hours after death Funeral or iteme 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. I □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No þ Specify: 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than . Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important: if liem 27 ie marked other tha
any Injury or other traumetic 5+ Professor/Instructor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Magdalen Cooke Vernon Mihm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy Tyler Husband 4356 Back Woods Road: Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/20/2006 New Cathedral Cem. Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwah Witzke Funeral Home of Catonsville, Inc. 21. Signatural Funeral Service Licers 1630 Edmondson Avenue; Catonsville, 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Cincheso /Medical Examiner wars if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 00 Due to (or as a consequent Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed c Due to (or as a consequence of) nding physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for i in the past 12 months?
1 Yes 2 No
9 Unknown Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 Yes 2/1 No To the newspace within 24 hours after death.

To the Funeral Director; After this certified in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (S. ecify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: 2 Medical Examiner: On Medical 29a. Certifier whe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title certifie 29c. License number 23a) (Type, Print) 30. Name and address ompleted ause of death (It of person w 10 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Registrar 2006

		1	For State Registrar	State of Ma	aryland		rtment of H			iene	36	36496
	q		1. Decedent's Name (First, Middle, Las	1)			0.45		2. Date of Deat Month		Year,	3. Time of Death
	Physicia /Medic		Regins	(V)	125	LOW	5101		Novem		00 6	10:00 AM
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	Location of Death		4c. County		
			Ellicott City Nurs				Ellico If Under 1 Year	tt City If Under 24 Hrs.	Data of Birth		oward	
	Funeral		5. Social Security Number 6. Se 216-24-5504	□M 25₹E		ast birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,			lace (State or Foreign try)
	Director	-	Usual Residence of Decedent	8	7				Dec.19,	1916	Mary	Land
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	B Mar	cto	Maryland Howard		E.	llicot	t City					1 Tes 2 No
	or 28	Dire	10e. Street and Number				10f. Zip Code		1	0g. Citizen of \	What Cour	itry?
	ath w	Funeral Director	9374 Paulskirk Di			7 140 1		1042		USA		an Indian
	tem tem	-in	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent B Armed Forces? 1 □ Yes 2√□ N		5. 13. 1	Yas Decedent of F Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		e - Americ ck, White,	
336	urs af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			I□Yes 2및 No	Specify:		Specify	Whi	te
215-0036	within 72 hours after death with the Maryland ene. Itan "ratural", or items 28a or 28a-f show fra McJical Exiz iliter: stat be notified at	ted	15. Decedent's Ed			16a. Deced	lent's Usual Occup	ation during most of work	vina .	16b. Kind of B	usiness/Ind	dustry
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	OO NOT use retired	d)		Donos I)1 on to	
C	filed with Hygien other the		8			Super	visor	40. Mashada Nasa		Paper I		
and	ould be filed with Mental Hygiene. Brked other than atic event, Ite I	Be	17. Father's Name (First, Middle, Last)	.1.4				18. Mother's Nam		walden Suman	10)	
Maryland	should nd Men marke	ဥ	Peter Wojciechows 19a. Informant's Name/Relationship (7			19h Mailin	n Address (Street	and Number or Rui		City or Town	State Zin	Code)
Ma	id 2 sho Ith and 27 is mu traum		Carolyn Widitz	Daugh	ter			k Drive;				
ē,	jes 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. of Health and Mental Hygiene. of Health and Mental Hygiene. or other traumatic event, Ira Marical Exteriliation and be notified.		20a. Method of Disposition	Daugn	20b. PI	lace of Dispo	sition (Name of natory or other place			20c. Location -		
e E			1 Buriat 2 □ Cremation 3 □ 4 □ Donation 5 □ ther (Specify			-		ery 11/1	8/2006	Baltimo	re,	Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	500		22	. Name and Addre	ss of FacilitySte	rling As	hton Sc	hwab	
0	e e e		C 7/10	M	127	0 1	630 Edmor	ome of Ca odson Ave	nue: Cat	onsvill	e, M	D 21228
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused one cause on each lir	the death ne.	. Do not ent	er the mode of dyir	ig, such as cardiac	or respiratory arr	est,		Approximate tnterval Between Onset and Death
8	Physician		trimediate Cause (Final disease or condition	a. Ather	rosci	erotic	Cardin	acidar	DIREGO	a.		Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as								
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	uence of):					-	
2	ited I Insit	min	Cause (Disease or injury									
3.6	be execuled sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):						
8760,	a × a	Physician/Medicai	(d						_		
9	leath certifica attending ph d for use as th	Med	IF FEMALE:									
Вох	ath ce ttendi	an/	23b. Was decedent pregnant in the past 12 manths?	23c. If yes, outcome 1 Live birth	2 Fetat	death 3	Ectopic pregnanc	,			te of delive inth	ery Day Year
0.		ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of de	eath 5∟	Other (specify)					
σ.	requires that the reen signed by th hould be detache	/ Ph	Part II. Other significant conditions co	ontributing to death be	ut not resu	alting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to th	ne cause of death?
Records,	uires sign	d by							1 🗆 Y	es 2 🗆 No	3 Prob	ably 4 Onknown
Ö	law req as bee 2 shou	Completed							24a. Was a		Were auto	psy findings available
Re	o 0	шо							autops perform	ned2	death? 1 □ Yes	mpletion of cause of 2□ No
Vital	ysician: The is certificate director, pag	BeC	25. Was case referred to medicat examiner?					26. Place of Dear	th (Check only on			
of V	S S	To	1 Yes 2 No	Hospital: 1 ☐ Inpatie		ER/Outpatien		4 Nursing Ho	ome 5 Reside			y)
n o	De je	iuo	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injui (Month, Day	ry y Year)	28b. Time of Injury	Wo		28d. Describe ho	w injury occur	red	
Sio	Attending r death. ector: After y the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		ury - At ho	me farm str	M 1 ===================================	Yes 2 □ No	28f. Location (Si	reet and Numb	er or Rura	I Route Number
Division	or A after Direc	Certification:	4 Homicide determined	building, etc	c. (Specify	()	eot, lactory, office		City or Town		07 07 7 1070	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	spital ours neral filled	alC		ysician: To the best								
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 ☐ Medicat Examone)	niner: On the basis of and manner sta		tion and/or in	vestigation, in my o	pinion, death occur	rred at the time, d	ate and place,	and due to	the cause(s)
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: All completely filled in by the fu	M	29b. Signature and title of certifier				29c. Licens			9d. Date signe		
			> E (lamb	•			030	641	/	Vovembe	15	2006
	4		30. Name and address of person who		eath (ttem	23a) (Type,	Print)	of Vand	1801	Maran	Ma	2006 plant 2/221
			Ramerh Sabapa		101 ar's Sinnat	ture .	KIVES IVE	LK KOWCI	1-01	IMOR	, rue	plane cices
• -	Sta Registi		NOV 1 7 2	.006 32. Hegistr	ingrae	903	July Book					

DHMH 17 Rev 1/2001

		Í	1 - For State Registrar	State of N	Maryland / Del	oartment e e <i>rtificate</i>			ental Hygie	7000	36497
	Physici		Decedent's Name (First, Middle, L.		iney Mason	. Jr.				Day Year Der 13, 2006	3. Time of Death 8:00 p.m M
16.	/Medic Examin		4a. Facility Name (If not institution, gi			·	wn, or Location	of Death	MOVEILIK	4c. County of Dea	
			9	725 Old Anna					tt City	ł	Howard
	Funeral			Sex 7. /	Age (In yrs. last birthda 87 Yrs.		ear If Under Pays Hours	Min.	8. Date of Birth (Month, Day, Ye	9. Bin	rthplace (State or Foreign ountry)
	Director		146-18-2080 Usual Residence of Decedent	<i>D</i>	87 Yrs.				March 12, 1	919	Delaware
	yland		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
	a-fet	ctor	Maryland I	Howard			Ellicott C	City			1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Co		2.40	10g.	Citizen of What C	•
	e 23a	ral	9725 Old Annapolis F		25			042	4. V N-		.S.A.
9	after de or item miner p	by Funeral	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Deceder Armed Force 1 Yes 22 If Yes, Give	\$?	If Yes, specify 1 ☐ Yes 28	Cuban, Mexica	n, Puerto R	ican, etc.)	14. Race - Am Black, Whi	te, etc.
္က	ural',	d b	3 Widowed 4 Divorced	Year or Dates						Specify:	White
215-(within 72 hours after death with the Maryland ene. Itan "natural" or iteme 23a or 28a-f ehow the Medical Examinar must be multied at	Completed	15. Decedent's E (Specify only highest gi		pleted) (Give kind of wor			st of working	g 16b	. Kind of Business Self I	Industry Employed
7	giene giene er tha	Com	Elomonially (6 12)	4		5	Sales Engir	neer			
<u> </u>	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Las	•			18. Moth	er's Name (First, Middle, Maid		
<u>\Z</u>	should ind Men marke umatic	2	John To	enney Mason	10h Ma	ilian Address (C	1	as as Ourse!		rine Miller	Zin Contal
<u>a</u>	d 2 st th and th and traur					-			ott City, Mar		Zip Codej
ē,	s 1 and f Health Item 27 other tr		Mr. Edmund Maso 20a. Method of Disposition		20b. Place of Dis		of	Da		Location - City or	Town, State
Ë	Peges nent of f int: If It		1 ☐ Burial 2-☐ Cremation 3 { 4 ☐ Donation 5 ☐ Other (Spec		All County	,		nc 11/1	6/2006	Sykesvill	e, Maryland
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or theme 23a or 28a-f show any Injury or other traumatic event, it a Medical Example must be multified at once.		21. Signature of Funeral Serv to Li	ity, MD 2104	2						
ı			23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	nplications that cause one cause on each	ed the death. Do not e	nter the mode o	f dying, such as	cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or a	as a consequence of):	ge "	w g es	1	enent	~ 6	2425
В	Examiner		Sequentially list conditions	Ď.	andtook	de	bilin	ul	eles		2 Mes
7	od it	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequen of):			-	Wit Cherman		
/	and and Il-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or a	as a consequence of):						
8760,	death certificate be executed etending physicien and of for use as the burlat-transit	dical E		4	, , , , , , , , , , , , , , , , , , , ,						
.89	tificate ng phy as the	0 .		_ u.	-					1	
Вох	eath certifii ettending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth		☐Ectopic pregr	ancy			23d. Date of de	
о. П	the dea y the et iched fo	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant 9□Unknown		Other (special	y)			Month	Day Year
σ.	res that the drigned by the	by Ph	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying caus	e given in Part I		23e. Did tobacc	co use contribute to	the cause of death?
rds	w requires been sig should be								1 🗌 Yes	2 No 3 □ P	robably 4 Unknown
Records,	2 2 2	Completed							24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
ta		0	25. Was case referred to medical				26. Place	of Death (1 ☐ Yes 2 Check only one)	No 1 1 Yes	: 2□ No
>		To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 ER/Outpati			ursing Home	Residence	6 □Other (Spe	cify)
o uo	Attending Ph ir death. ector: After th by the funeral		27. Manner of Death Natural 5 Pending Accident investigation		njury 28b. Time Day Year) Injury	of 28c.	Injury at Work? 1 Yes 2	- 1	d. Describe how in	njury occurred	
	호플芹트	Certification:	3 Suicide 6 Could not l 4 Homicide determined	286. Place of I	njury - At home, farm, s etc. (Specify)	street, factory, of	fice	28	f. Location (Street City or Town, St		ural Route Number,
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical			st of my knowledge, dea of examination and/or stated.						
	vithin 2 To the comple	N.	29b. Signature and title of certifier		1	29c. L	cense number		29d. l	Date signed (Mont	h, Day, Year)
				M	Nhyi'a		29	769		11/17/	06
	10		30. Name and address of person who	completed cause of	death (Item 23a) (Type	Print)	LNE	11.5	n Al	Bult.	and 2728
	Sta	te ar	31. Date filed (Month, Day, Year)	32 Regis	strar's Signature	46 -		Makel	0	70	

DHMH 17 Rev 1/2001

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ena Mae McFac	1	l - For State Registrar	State c	of Maryland		nent of F cate of E		d Mental H		g. No. 200	16 36491
Physicia Medical Examir	n/	Decedent's Name (F	First, Middle, Last)	Mae	00 1	Fad	den		Date of Death Month November		3 Time of Death 1852 hrs
P . :		4a. Facility Name (if no		street and number	1110	- ' '	, ,	Location of Death		4c. County of De	
		Bon Secours I	<u> </u>	17.4	- O leath		Baltimore	Titling - Odilar	Doto of Birt	\	1/A
Funeral Director	4		7046 1 I	M 2 F	e (In yrs. last b	_	If Under 1 Year Months Days			6- 1950 Fo	Birthplace (State or reign Country) Maryland
au	- 1	Usual Residence of De 10a State 10i	b. County		10c. City, Tow	n or Location		-			10d Inside City Limits
*	5	md:	\sim	1A		Ba	etin	roce			1 Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once	Director	10e. Street and Number	Bri	ce Sa	4.	1	Of. Zip Code	-17	10	g Citizen of What C	ountry?
hours after death with the Maryland natural", or items 23a or 28a-f sh Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married	2 Married			If Yes,	specify Cuban,	Mexican, Puerto	pecify Yes or No- Rican, etc.)	White, etc	nerican Indian, Black,
ural",		3 Widowed 15. Decedent's Education		f Yes, Give Year or Dates: / highest grade cor	npleted) 16a		Usual Occupation	specify on (Give kind of v	work done	Specify: 16b. Kind of Busine	ss/Industry
2 -	Completed by	Elementary/Second		College (1-4 or	5+)	during most	of working life.	DO NOT use reti	red)	16 . 14	imore
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than c event, the Medics	a	17. Father's Name (Fir	n n		den			man	,	Dicker	1
, MD 27 and 2 should ealth and Mc tem 27 is ma traumatic e	우	19a. Informant's Name			o ther	9b. Mailing A			Rural Route Num	ber, City or Town, St	ate, Zip Code)
e, M and 2 Health item 2 r traur	ŀ	20a Method of Oispos	ition		20b. Place	of Disposition	n (Name of cem		Date	20c. Location - City	or Town, State
Baltimore, Permit. Pages I an Department of He Important: If ite		4 Donation 5	Other Specify		ale ,		remoria	al A-	18-06	Kandal	letorn, md.
Balt permit. Departi Import		21. Signature of Funer	al Service License	96			ne and Address		70 Fred		Pass eto, nd, 2,1229
Physician	-	23a Parti. Enter the c	disease, or complications cause on each	cations that caused	the death Do	not enter the	mode of dying,	such as cardiac c	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Fin or condition resulting i	al disease a	Atheroscle		rdiovaso	ular dise	ease			Death
And the second	er	Sequentially list condi	tions, b_	ue to (or as a cons							
st ts	Examiner	cause. Enter Underlyi (Disease or injury that events resulting in dea	initiated C	ue to (or as a cons	equence of):						
ecu and tanc	edical	X UNPENDED	d	AMENDED #22	DIT 07	ME	060 10/1	11 /oc mm			
760, cate be est		IF FEMALE:		AMENDED #23a 23c. If yes, outcome	me of pregnanc	penyll, g	802, 12/1	_		23d Date of deliv	very
Box 6876 death certificate the attending phy ed for use as the b	cian	23b. Was decedent pre past 12 months?		1 Live birth Pregnant at	t time of death		death 3 (Specify)	Ectopic pregna	ancy	Month	Day Year
BO) ne death the att	Physician/M	1 Yes 2 No		9 Unknown					Dog Duran		As the second of death?
, P.O. B res that the d signed by the be detached		Part II. Other signification Human imm		contributing to deat ency virus		_	erlying cause gi	iven in Part I.			to the cause of death? robably 4 Unknown
ords, w require s been si should b	Completed by								24a. Was a		autopsy findings available to completion of cause of
Reco	omo								perform		
tal Rec	Bec	25. Was case referred examiner?		spital: 1 Inpatie		0 1 -111 0	T.	of Death (Check			
of Viding Physical After this funeral dis	on: To	1 ✓ Yes 2 27. Manner of Death 1 🐰 Natural	No	28a. Date of Inju (Month, Day,	ent 2 🗸 ER/ ury (ear) 28b	. Time of Inju	ry 28c Injur	y at Work?	•	Residence 6 Of	her
Division of Vital Records, pital or Attending Physician: The law require ours after death reral Director: After this certificate has been sifiled in by the funeral director, page 2 should be	Certification:	2 Accident 3 Suicide 6	Investigation Could not be determined	28e. Place of Ir	njury - At home,	farm, street,			28f. Location (S or Town, St		Rural Route Number, City
Hospi 24 hou Funer tely fil		Concording	ertifying Physicia		-					e(s) and manner as s	
To the within To the comple	Medical	29b. Signature and title		and manner stated	7		29c License	number	-	29d. Date signed (Month, Day, Year)
		Zaha	Mo	1	1		O.C.N	И.E.		November 14,	2006
		30. Name and address		empleted cause of cant Medical E			Street, Baltii	more, MD 21	201		
	ate	31. Date filed (Month,	Day, Year)		ar's Signature	Cart -					
Regist		NOV 1	7 2006	Miles	N A	DICHAL	_				
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06-08657 Mary Mcfadden

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006	364	
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•		1- For State Registrar	Certificate of D	eath	Reg	J. No. 2006	36495		
Physicia ledical Examir	n/	1. Decedent's Name (First, Middle,Last) Mary McFadden			Date of Death Month November	Dav Year	3. Time of Death 0601 hrs		
The state of the s	ı	4a Facility Name (if not institution, give street and number) Maryland General Hospital		City, Town, or Location of I Baltimore	Death	4c. County of Death			
Funeral Director	- 1	5. Social Security Number 6 Sex 7. Age 1 M 2 X F		f Under 1 Year If Under 2 Months Days Hours		(MM/DD/YYYY) 9. Birt 29, 1958 Foreig Cou			
5-0036 led within 72 hours after death with thygiene. thygiene, other than "natural", or items 23, the Medical Examiner, must be not	mpleted by Funeral Director	Maryland N/A 10e. Street and Number 807 Wedgewood Road 11. Marital Status 1 St Never Married 2 Married Armed Forces?	ver in U.S. 13. Was D If Yes, No 1 Ye leted) 16a. Decedent's during most	of Zip Code 2 1 2 9 ecedent of Hispanic Origin specify Cuban, Mexican, Paragraph Specify: Usual Occupation (Give kir of working life, DO NOT us	? (Specify Yes or No- ruerto Rican, etc.)	16b. Kind of Business/li None	tates can Indian, Black, ack		
Baltimore, P permit. Pages I and Department of Healt Important: If item injury or other tran	္	19a Informant's Name/Relationship (Type, Print) Nikitta Adams - Daughter 20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from Stat	20b. Place of Disposition crematory or other Western Ce	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 867 Wedgewick Road Baltimore, Maryl Place of Disposition (Name of cemetery, prematory or other place) Stern Cemetery 22. Name and Address of Facility Calvin L. Williams Funeral Service, P.A. P.O.Bcx 11651 Baltimore, Maryland Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart					
Physician /Medical xaminer	2 0	Immediate Cause (Final disease or condition resulting in death) a Broncho neu Due to (or as a consect	monia due to tr				Approximate Interval Between Onset and Death		
ecuted and transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consect d.	quence of).						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be evecual within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - ra	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown Part II. Other significant conditions AMENDED #23a 23c. If yes, outcom 1 Live birth 4 Pregnant at t 9 Unknown contributing to death	2 Fetal me of death 5 Other	death 3 Ectopic p	1. 23e. Did tot	pacco use contribute to	Day Year		
Division of Vital Records, F tal or Attending Physician: The law requires its after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be	Be Completed	25. Was case referred to medical		26 Place of Death (C	24a Was a autops perfor 1 ✓ Yes 2 heck only one)	sy prior to o med? death?	utopsy findings available completion of cause of es 2 No		
ivision of Vita or Attending Physici after death. Director: After this or i in by the funeral direc	^L	examiner? 1 V Yes 2 No 27 Manner of Death 1 X Natural 5 Pending 2 Accident Investigation Pospital: 1 V Inpatier 28a Date of Injur (Month, Day,Ye)	y 28b. Time of Inju	ry 28c. Injury at Work?	28d. Describe h	Residence 6 Other			
Divis Hospital or A 24 hours after Funeral Directely filled in b	Certification:	4 Homicide Could not be determined (Specify)	ury - At home, farm, street,		or Town, St	<u> </u>			
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, death occurred ination and/or investigation	n, in my opinion, death occi	be, and due to the cause ourred at the time, date a	and place, and due to th	ne cause(s)		
	Σ	29b. Signature and title of certifier		29c. License number O.C.M.E.		29d Date signed (Mo November 15, 20			
		30 Name and address of person who completed cause of de Ana Rubio MD. Assistant Medical Exam		eet, Baltimore, MD 2	21201				
Si Regis	tate trar	31. Date filed (M) 10 Day Year 2006 32. ogistrar	s Signature	E					

			1 - For State Registrar	State of Ma	arylan	d / Depa <i>Cei</i>	artment <i>rtificate</i>	of He	alth ar eath	nd Men		iene 2 og. No.	2006	36500
İ	Physici /Medic		1. Decedent's Name (First, Middle, La BLANCHE C.	NAGLE	_						vembe		4 , 200 6	3. Time of Death 10:15 A M
\$ 100	Examir Funeral Director			n Nursing		ne last birthday) Yrs.	If Under 1	Balt Year	i moi f Under 24 Hours	re	Date of Birth Month Day, C • 25		9. Birthp	lace (State or Foreign
	ס	or	Usual Residence of Decedent 10a. State 10b. County MD		10c. City, Town or Loc			timo	ore					Od. Inside City Limits X□ Yes 2□ No
	with the 3a or 28a-	Direct	10e. Street and Number 1601 E. Belved	dere Aven	ue		10f. Zip 0	ode 21239			10	of What Coun	try?	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23a or 28a-f show eny Injury or other traumatic event, the Madical Examerar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marned 3 V Widowed 4 Divorced	1 Never Married 2 Married Married 2 Married Married 2 Married Married 1 Mar			Ever in U.S. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P				Yes or No- n, etc.)		Race - Americ Black, White, becity: Wh	
21215-0036	od within 72 ho giene. er then "natur er the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1 2	ducation ade <i>completed)</i> College (1-4or 5	+)	(Give life. l	dent's Usual kind of work DO NOT use creta	done dur retired)	on ing most o	of working		16b. Kind of Business/Industry Financial Ins		,
Maryland	uld be file Mental Hy Irked oth	To Be (17. Father's Name (First, Middle, Last Charles Whit	,				1:		s Name <i>(Fir</i> nche	st, Middle, N Macy	Maiden Su	тате)	
	and 2 sho salth and 1 o 27 is mu		19a. Informant's Name/Relationship (Dr. Conrad Nag)	,, ,		19b. Mailin 3 2 0 0	Address (Street and Oakw	d Number 700d	or Rural Ro Road	ute Number, -Oxfo	City or To	own, State, Zip Michig	code) 48370
altimore,	t. Pages 1 rtment of He rtent: If Iten		20a. Method of Disposition 1 Name Surial 2 Cremation 3 Care 4 Donation 5 Other (Special Control of the Control of t	fy)	Mor	Pa	rk rk	or place) Or 1 a		Date 1 – 1 7 –	2006	Park		Maryland
Ba	Depar Impor eny fr		21. Signature of Funeral Service Lice	ME Jado	4	EV AN	Name and VANS ND CR	FUNE EMAT	RAL	CHAP SERV	TCES	Pa	Harfo rkvill	rd Road e,MD 21234
8760,	Physician /Medical Examiner building from the prijel-transit the prijel-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cuelovas cular Accident Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										Approximate Interval Between Onset and Death Flyering Jyloury	
P.O. Box 6	death certifi e ettending id for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic preg					23d	. Date of delive Month	ry Day Year
	iaw requires that the de es been signed by the e 2 should be detached f	þ	Part II. Other significant conditions of	contributing to death bu	ut not resu	Ilting in the un	nderlying cau	ise given	in Part I.		23e. Did tob		,	e cause of death?
Division of Vital Records,	The ate h paga	Completed	Cardiomyopa	thy						_	24a. Was an autopsy perform	/	4b. Were autop prior to con death? 1 \(\text{Yes}	osy findings available apletion of cause of
<u> </u>	Physicial this certical director	To Be	25. Was case referred to medical examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \)	Hospital:	nt 2 🗆 l	ER/Outpatien	t 3 DOA	104			eck only one 5 □ Residei		Other (Specify)
sion c	ner fe	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		Y Year)	28b. Time of Injury	M 280	i. Injury at Work? 1 ☐ Yes	s 2∐No		Describe hov	w injury oc	ccurred	
Ž O	호 를 들 으	Certifi	3 ☐ Suicide 6 ☐ Could not be determined	building, etc	:. (Specity	")					City or Town,	, State)		Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier (Check only one) Certifying Pt Certifying Pt Certifying Pt Certifying Pt Certifying Pt	nysician: To the best on miner: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred at restigation, in	the time, n my opini	date and pion, death	place, and d occurred at	lue to the ca the time, da	use(s) and te and pla	d manner as sta ice, and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	& MO				License n				6 4	gned (Month, L	Day, Year)
	U		30. Name and address of person who CARL SPERLING	completed cause of de	eath (Item	23a) (Type, I	Print)			MI		239	-	
ž	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 7 2	32. Registra		ure A	and s							Tank

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